MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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International Trade Center
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COMMISSIONERS PRESENT:

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RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

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P R O C E E D I N G S

DR. WILENSKY: Julian?

MR. PETTENGILL: Good morning. We're here to discuss first, chapter one, the overview chapter for the report. We sent you a draft that was in several pieces, yet to be knit together, and also missing a summary of our conclusions or review, which we will put in early on in the chapter so that we catch everyone's attention right up front.

This morning, I'd like to start with what are the objectives of the chapter. We really wanted to provide background and context for the rest of the chapters in the report and to provide the overall sense of your judgment about what the situation is in rural America, the extent to which there is a problem, the extent to which that problem is related to Medicare and Medicare's policies, and also some consideration of to what extent other policies outside of Medicare might be appropriate to pursue, without being specific about which ones because you haven't discussed that much.

We begin with how rural areas are defined, then talk a little bit about what rural health care looks like according to the literature, and the factors that affect demand and supply in rural markets, and then we talk about regional differences in market conditions across the country, that is the diversity of market conditions, the supply responses in each area among providers, and patterns of care, which is the use rate part of the analysis.

And then finally, a section that was not included in the draft but will be written, some discussion of the implications for Medicare and other policies.

I wanted to show you some information that we have pulled together with the help of some people at the Rural Research Center at the University of North Carolina.

We have two principal definitions of rural and rural areas in this country at the moment, that are widely in use. One is the census definition and the other is the set of definitions developed by the Office of Management and Budget. Census defines rural -- in fact, they both define rural as in the negative, that is not urban. Census does it

by saying that people and buildings and territory are urban if they're included in an urbanized area, which is defined by population size and density. Or they are in a place with 2,500 or more people outside of an urbanized area.

I would personally not like to be in charge of operationalizing that definition myself.

But in any event, OMB takes the census data and defines metropolitan and non-metropolitan, which we translate as urban and rural, based on the characteristics of the county, population size, relationship to a city, population density, commuting patterns. The idea there is that a metropolitan area is one that is social and economically integrated with a city. And anything beyond the central core county and the outlying suburban counties that are related is non-metropolitan.

Depending on which definition you use, the rural population is either 25 percent under the census definition of the population, or it's 20 percent under the OMB definitions. The reason that you get such a big difference is that a lot of rural, so-called non-metropolitan counties,

have in fact urban areas within them. And conversely, a lot of metropolitan counties have rural areas within them, areas that are not urbanized. That's what accounts for the difference.

This map gives you an idea of the overlap. The very dark areas are the urbanized areas. The gray areas are the counties included in the MSAs. You can see that the very dark areas do not fill up more than a small fraction of the space in quite a few so-called metropolitan counties. You don't see very many dark spots in the white areas, which are non-metropolitan counties, but there are some out there.

Because metropolitan and non-metropolitan just define two broad categories, they kind of leave you with the impression that rural is rural and urban is urban and they're both pretty homogeneous internally. To get at the diversity within them, various researchers -- beginning at the Department of Agriculture actually -- have defined alternative classifications of counties, one of which we use, the urban influence codes shown in the next overhead.

You saw this diagram at the last meeting. The UIC

codes are based on whether the county is included in a metropolitan area and, if so, what size metropolitan area, over or under 1 million population. And then for non-metropolitan counties, they're classified according to whether the county is adjacent to an urban area, what size urban area it's adjacent to, and what is the size of the largest town in the county.

Now for many of the analyses that we have done in this report, we use the UIC categories but we collapse them. We have collapsed them in somewhat different ways in different places. The main reason for collapsing them in most cases is that we have a limited sample of information. Consequently, we can't really look reliably at some of the counties.

In others we collapse them because of the relationship, there really is no difference. For example, it turns out that adjacency, in many instances, is much less important than the size of the largest town. That's what makes a difference in the adjacency.

So in many cases, we collapsed one and two so we

show a single category for urban. We collapsed three and five and four and six, which gives us categories based on town size. We end up with six categories.

I put in the paper the rural/urban continuum codes. That's an equally interesting way of classifying rural and urban areas but it's not the one we chose to use for our purpose. It is in the report, but I don't see the need to discuss it.

For a lot of the work for this chapter, we wanted to be able to characterize the market conditions that exist in different rural areas and we found that the best way to do that, since the hospital is essentially the center of the health care delivery system in rural areas, we decided to use hospital markets as the unit of analysis.

We defined them as indicated on the overhead, or I should say our friends at the Rural Health Research Policy Analysis Center defined them using patient origin data from Medicare to build a hospital-specific market for each hospital that includes all of the zip codes that together account for 80 percent of the discharges for that hospital.

And then we took zip code data from Claritus Corporation, which is largely census data, and calculated means and medians and what not of population characteristics for the zip codes collected in each hospital market.

The next overhead shows the geographic distribution of those markets. Probably the xerox in front of you isn't wonderful. I know mine isn't.

I think the central fact that sort of leaps out at you, just from looking at this map, is that there are enormous differences in hospital density across the country. This is no great surprise. There are many more hospitals much more tightly packed together in the East than in the West.

DR. NEWHOUSE: Julian, is there any difference between the marks that cross and the marks that go this way and the marks that go that way?

MR. PETTENGILL: There are two levels of crosses here. The lighter level is one hospital. The darker one is a pair that are right together.

DR. WAKEFIELD: So the X is a pair?

DR. ROWE: The X's are rural hospitals.

DR. REISCHAUER: There's a back slash and a forward slash.

MR. PETTENGILL: I think that's more a function of the xerox than it is the actual map. When you see the map published -- we will perhaps play around with alternative symbols that might show up more clearly.

Basically, there is a difference. The lighter gray ones represent a single hospital, the darker ones represent a pair that is so close together that you can't print a separate symbol.

MR. SMITH: The direction of the slashes doesn't tell us anything?

MR. PETTENGILL: No, nothing. Ignore that.

MS. RAPHAEL: I've been trying to understand the issue of distance and the 35 miles, which you will come to later. But when have earlier that something is adjacent to an MSA, how is adjacent defined?

MR. PETTENGILL: Adjacent is in the context of the county. The county is adjacent to an MSA.

DR. REISCHAUER: Some of this is really amazing here, because if you go to Nevada and New Mexico here, and you look at somebody who is living in the far reaches of a metropolitan area, that's like the moon where they are. And yet we have them classified as metropolitan.

MR. PETTENGILL: Yes, that's true. Look at Riverside County or San Bernadino County or Duluth County.

DR. REISCHAUER: Right, they're all the way across the state.

MR. PETTENGILL: Same problem. You have one part of the county is dense, urban area and 100 miles away, in the same county, you have a completely rural area.

There is a feature of Medicare policy for the swing bed criteria where Medicare uses something, by law, called the Goldsmith Modification, which is an attempt to identify portions of urban metropolitan counties that are rural. Which is why, when you look at the data and you see that we have hospitals that have swing beds but they're located in metropolitan areas, and you scratch your head and you say why does that happen? How can that be?

Swing beds are supposed to be for rural hospitals. Well, this is how it happens. The criteria that Medicare uses, in fact, the Goldsmith Modification identifies such areas within metropolitan counties that are, in fact, rural.

MR. DeBUSK: Julian, can you overlay this with the wage index region?

MR. PETTENGILL: The wage index regions are metropolitan statistical areas, the grayed out areas on the map, and non-metropolitan collections of counties in each state. So all the counties that are not metropolitan in a state are aggregated together, and that's considered to be the rural labor market area.

MR. DeBUSK: So that could be overlaid though, right?

MR. PETTENGILL: In effect they are. The light gray areas are the MSAs.

MR. DeBUSK: So this is the wage index areas within the state?

MR. PETTENGILL: Subject to one proviso. The boundaries of the MSAs have not been drawn in here. So

you've got some grayed out areas that represent multiple MSAs that happen to be adjacent to each other, they're not single markets. But if you would like to see a map like that, I'm sure we could include one in the hospital chapter where it would be more relevant.

MR. DeBUSK: I'd like to see it.

MR. HACKBARTH: Julian, I still don't understand the symbols on this map. The X's are rural hospitals, judging by the key. I don't understand what the single slashes are.

MR. PETTENGILL: Unfortunately, the xerox I have to look at is probably even worse than the one you have, so I'm not sure that I can --

MR. HACKBARTH: It doesn't look like it's xeroxing. These are clearly defined marks on the map.

MR. PETTENGILL: Actually these are all X's. It is the xeroxing. There is no difference. If it slants this way or it slants this way, it doesn't matter.

MR. HACKBARTH: These are all rural hospitals.

MR. PETTENGILL: They're all X's. I have seen the

original PDF map and they're X's. They will print in the document, in the report, much better than you see here. The problem here is that you can't xerox this kind of stuff very well.

I think we want to move on.

I included a section in the chapter that collects thoughts about rural health care from a variety of articles that I managed to squeeze time to read. And also characterized it as painting a fairly grim, gloomy picture, which I think it does. I mean, the literature says providing health care in rural areas is a struggle and you have multiple problems that you have to overcome.

The factors they've identified, in particular, are the size of the market, you have relatively few people so you have difficulty attracting professional staff; the population dynamics in many cases, the population is declining as portions of the working age population have moved out to seek employment elsewhere. You have an aging population in many areas. You have high levels of concentration of ethnic and racial groups in some areas that

represent a different set of problems, some of it cultural, differences in attitudes and that sort of thing. Some of it is sort of standing for other things, like the extent to which people have health insurance.

Physical isolation, we're always hearing about long distances that people have to go to receive care. Household income and unemployment. And obviously the proportion of the population who is uninsured. Many of the people who live and work in rural areas work for small employers who are much less likely to offer health insurance, so there's a smaller fraction of the population that is insured. Those that have insurance often have less coverage than you would find elsewhere.

We don't have, unfortunately, detailed geographic information on all of these variables. Health insurance, in particular, is a weakness. There just isn't a good source for that. But we do have information on the others.

When you look at the geographic patterns here I think what you see is that you have two main patterns, one in the West and one in the South and East. You also have

some differences along the Canadian border, where you have kind of a combination of the two sets of factors.

In the West the main factors operating are small population size, physical isolation, and declining population and an aging population. In the South it's a different constellation. It's relatively low household income and relatively high unemployment and high concentration of racial and ethnic minorities.

The next table shows some of that information, contrasting the East and the West. We did it for all markets in the East and the West. By the way, East here is defined as the five census divisions that all have New England, Middle Atlantic or East in their name. The West is the four census divisions on the western side of the country, which is Northwest, North Central, South Central, Mountain and Pacific.

The differences are not so striking when you look at all of the markets, but when you go down to the bottom quartile by population size of the market, that's the small group on the table, then I think the differences really

1 become quite striking regarding the likelihood that you have
2 declining population, that you're isolated.
3 Isolated, by the way, means that you don't have
4 another acute care hospital within 25 miles, which is not a
5 terrifically restrictive definition, but if you do 35 miles
6 the pattern looks very similar geographically.
7 DR. ROWE: Julian, can I suggest, given that we
8 have a tremendous volume of material and some of these
9 chapters are very long and detailed, a tremendous number of
10 things to do, that maybe this analysis or any subsequent
11 subanalyses about this, might be dispatched. I think it's
12 bad enough we've got rural versus urban. Now we're going to
13 have West versus East. It just lines up another way that
14 people can fight about something but really doesn't add
15 anything to the questions about Medicare policy in terms of
16 rural versus urban, I don't think.
17 MR. PETTENGILL: I think what it adds is that
18 neither East or West nor rural versus urban is really the
19 issue. The issue is what are the market conditions? What
20 are the problems you face? And they're different in

different places. The obvious implication is that the policy answer, to the extent there is one, is going to be different in different places. There's no one answer.

DR. ROWE: I certainly accept that, but I wouldn't want the data presented in such a way so it looks like the East is being disadvantaged compared to the West or vice versa, because it would just line the Congress and the Senate up on the East versus the West, as opposed to rural versus urban. Or maybe the next slide is North versus South, I don't know.

MR. PETTENGILL: Actually I think the maps do a much better job of saying you have -- if you go to the next map, for example, this is population size of the markets. This identifies the small markets.

By the way, small here means that the total population of the market area is less than 11,200 people. That's what the quartile definition is, 11,200 people in the market. That's not very many people.

And what this map says is that if you just look at small population you've got markets scattered -- now they're

concentrated heavily in the Midwest and the Northwest, but there are markets scattered all over the country that have very small populations.

DR. NEWHOUSE: Julian, I wonder if this isn't apples and oranges, if I understand this right. If you've got a 20-bed hospital and you go through the zip codes that account for 80 percent of its discharges, you're probably going to have the zip codes right around it and you're going to get a population figure like you got. Whereas if I have a 200-bed hospital, I'm going to inevitably have a lot more zip codes and more population, so it will look like a bigger market area.

MR. PETTENGILL: I have no doubt that's true. On the other hand, there's a very strong association between the degree to which the hospital is isolated the size of the market.

DR. NEWHOUSE: But it doesn't necessarily mean that it's isolated, just because it draws on a few zip codes that are nearby it and that fills it up.

MR. PETTENGILL: But we're not defining whether

1 it's isolated or not based on how many zip codes it has.
2 It's based on the distance to the next nearest hospital.
3 DR. ROWE: But the point is, if you take the
4 University of Iowa Medical Center, which is this huge, very
5 elite place that is enormous and it must draw from five
6 states around that area. That would like look like a huge
7 market. They just happened to build a huge referral medical
8 center there in the middle of Iowa. I don't see what that
9 adds. I guess I'm sort of saying what Joe's saying.
10 DR. WAKEFIELD: Is part of what you're trying to
11 demonstrate here -- and I might be misinterpreting, but I'm
12 looking at the same map -- is the distance between or to
13 other hospitals? Is that part of what you're trying to
14 capture here?
15 MR. PETTENGILL: No, we have another map that
16 shows the isolated hospitals. It's not the next one but the
17 one after that. Those are hospitals where the next nearest
18 hospital is at least 25 miles away.
19 We have a lot of hospitals in the Midwest -- if
20 you go back to the small market base, it's true that big

hospitals would tend to draw from a much wider area and therefore have a bigger population. There's no question about that.

Many of these hospitals the market is defined essentially by one zip code because zip codes essentially align with the town and they're relatively small hospitals. That's their service area. And the population available to support them is the population that's right there.

DR. NEWHOUSE: But that's the issue. Suppose there's another hospital in a city that's 15 miles down the highway and they each draw from their own cities. If one hospital closed, the people 15 miles down the highway might come to the other hospital and it would grow.

There's an inherent problem defining market area. It's a classic problem and you're basically defining it off observed use. Conceptually, it could be better defined off of potential use but we don't observe that, so this is the best we can do.

DR. REISCHAUER: If you look at Kansas, it brings your point out. There's lots of small markets but not many

isolated ones.

MR. PETTENGILL: That's right.

DR. WILENSKY: There's nothing inconsistent with the kind of information you're presenting and making the point that I think is worthwhile, that Joe just made, which is that what we are looking at is observed market and, in principle, the market could be different particularly if there were different hospitals that were available.

I think that's a good point to make, so that when we're looking at these observed realities, we understand the context in which we ought to interpret these observations.

MR. PETTENGILL: I don't have any problem with that. In fact it comes in later when you start thinking about low volume adjustments and whether they should be restricted. It has an obvious application.

DR. WILENSKY: I think the point is worth making, but I don't think it takes away from the usefulness of how you've laid the information out.

MR. HACKBARTH: One of our challenges, one of our responsibilities is to try to simplify and make very

complicated situations understandable to policymakers. I'm worried about people getting lost in this succession of maps and data. I'm struck by the point that Bob pointed out, the seeming difference between the two maps when you look at Kansas.

I wonder if we ought to be trying to simplify this to bring home the basic points to our audience. This first map, with small market base, I don't find helpful in dealing with the policy problems. I think I understand what it means, but the critical issue -- given the earlier data you presented about what the problems are -- it's whether they're isolated or not, not whether they have a small market base.

MR. PETTENGILL: Actually that's not. You would think -- let's go to the map on isolation. You would look at that and you would say okay, these are isolated hospitals, these are the ones that have the small markets, and they would have low volume of demand, not just for Medicare but on the private side, as well. And that's what the problem is.

But in fact, there's not a close relationship between isolation and low volume. I have a table. If you go down further in your stack, it's the next table.

There is a relationship, but it's not a very strong relationship.

MR. HACKBARTH: But isn't the ultimate question, Julian, what happens if this hospital were to disappear? The fact that these isolated hospitals may not be low volume signifies that they're collecting people from a broad geographic area and that's a good thing.

Whereas, if we just have small market hospitals and they disappear and there's one down the road, is that a major public policy problem?

MR. PETTENGILL: It's certainly one of the questions. It's not the only one. I think part of the problem is that people tend to associate isolation with financial difficulty and there's not a strong association. Some isolated hospitals are, in fact, doing badly financially and are therefore at risk. And the population they serve is potentially at risk for that reason.

But in many cases, the isolated hospitals are not doing badly and they're not at risk. So it's a question of what sort of problem you want to solve.

DR. REISCHAUER: But I guess the question is what is the problem with small market base? One that is one town away and has equally small -- what is the problem? They might be in bad financial shape, but we don't have a potential access problem if one closes.

MR. PETTENGILL: That's why I tried to talk about clusters of problems because small population base by itself is one risk factor. It doesn't mean you have a problem. You have to put it together with a couple of others before you have a problem.

DR. ROWE: I think the issue is for me that many of the characteristics of some of these entities that are within the population we consider rural are terms that are laden. So when we use them, they sound bad. Like small market sounds bad. Isolated sounds bad.

It may not be bad. It may be that you have three hospitals in an area and they're all one-third full, that

two of them should close and then you have one left that's full and is doing well. And then you say oh my god, it's isolated.

My concern is that the way we're using these terms implies things that may not necessarily be there.

DR. NEWHOUSE: Julian, in the spirit of simplifying this, maybe you want to present the union of some of these characteristics rather than all these maps with each one singly.

MR. PETTENGILL: I'd have to try combinations like that and see what they look like.

DR. WILENSKY: I think the discussion, you might need to lead to that point and to talk about the issues initially as though these are all factors and to talk about why the factor may or may not be important, but to actually show pictorially the union which becomes now -- the intersection of these issues that becomes a problem.

So both in response to a comment I think Glenn made earlier, that we not overwhelm the reader with information, so you lead up to it. These are issues that

have been raised that may or may not sound as though they're problematic in terms of the term that is used, but the problem -- to the extent there is one -- appears at their intersection, here's what it looks like when you get small market or isolated and bring them together.

That might allow both the information initially, because it's hard to have the discussion on a two or three dimensional basis. But to approach that in that manner.

MR. PETTENGILL: I can certainly try that. What I had in mind with some of these things is to put four of these maps on a page, so that they're all right together. So if you had small market base and declining population and aging, and so on, and then the combination, you would see it all in one page.

DR. WILENSKY: The question is whether you could see that with that.

MR. PETTENGILL: I think the geographic patterns are strong enough and I've tried printing them four to a page, and I think it really does show more clearly,

actually, than looking one at a time.

DR. ROWE: Julian, it's clear you're going to do this, we're not going to talk you out of it.

[Laughter.]

MR. PETTENGILL: Jack, if it turns out that a map showing the combination is much more clear, I'll use it.

DR. NELSON: I'll have an easier time making a judgment about this after I've heard the rest of Julian's presentation.

MR. PETTENGILL: I think we can skip through some of this. The striking pattern in the South is low income and high unemployment. That map is a combination. That's South and East, and the pattern is pretty much where you would expect it to be.

The one thing I don't like about this is that this is nominal income. In other words, it doesn't reflect any adjustment for differences in the cost of living, and obviously that matters. But there isn't any good way to make an adjustment. We tried fiddling around with a couple of things, but it doesn't really change the pattern in any

event. I don't think there's anything really surprising here.

This suggests that there's a different problem in that area than you would see out west.

The consequence, a lot of times, of having a problem is that you end up with a provider that is operating at very low volume, and low volume is a major risk factor for poor financial performance. You'll see some of that later this afternoon in the data from the hospital chapter.

The analysis also seems to suggest that not all of these factors are all that important. The ones that seem to matter the most are small population, declining and aging population, which the intersection of them together is pretty strong, low income and high unemployment.

One of the consequences, as I said, is low volume if you have weak markets. But you can get to low volume a number of different ways. You can get there because the market base supporting your health care delivery infrastructure is weak. You can get there because you have a number of nearby competitors. Which reason got you there

1 matters from a policy point of view.

2 DR. NEWHOUSE: Are you going to distinguish those

3 reasons in the charts?

4 MR. PETTENGILL: I don't know that I can

5 distinguish them directly. I can show where markets are

6 weak because of either small population that's declining and

7 aging, or because you have low household incomes and high

8 unemployment. It doesn't follow that all of those markets

9 have low income. Only a fraction of them will. I could try

10 the intersection of all of that.

11 DR. ROWE: Julian, I'm thinking of the

12 Medicare+Choice program and I'm looking at these

13 characteristics and I'm thinking that some of these might be

14 factors that would lead to a failure of Medicare+Choice

15 programs in an area because your population is older and

16 therefore utilization is higher and there's a smaller

17 population, not enough to handle the infrastructure, nearby

18 competitors, et cetera.

19 It would be interesting if you had a composite of

20 where these different major risk factors coexist, if you

also then sort of took a look at where the Medicare+Choice markets no longer exist, or no longer are problems, whether or not that is an overlay. That might be a proxy in some way for the market isn't there, if you know what I mean. It may be a useful kind of phantom measure where the market isn't doing well in something that's market based rather than demographically based.

MR. PETTENGILL: I don't know. I'd have to think about that one. I don't know if I would buy that, that the presence or absence of Medicare+Choice plans is a clear indicator that the market either is or isn't there. It is or isn't there for Medicare+Choice plans, but that's not the same as saying it is or isn't there for fee-for-service providers.

DR. ROWE: That's my question.

MR. PETTENGILL: I don't know. We have fee-for-service providers in a lot of places where there's no Medicare+Choice plan.

MR. SMITH: Julian, I was struck by what seemed to be an asymmetry in this list. Small population, declining

population, and low income seem to me part of what yields low volume. That low volume isn't independent of those first three, and that in reading the whole chapter it seems to me that -- to the extent that we can get a thread through the whole thing, that low volume appears to be it.

I'm struck by including it, as if low volume were an independent risk factor, rather than an artifact of the first three, which it seems to me your argument would lead us to.

MR. PETTENGILL: No, I'm much more inclined to treat it as an outcome, rather than as a risk factor. Yes. I agree.

MR. SMITH: It would seem to me it would help us think about what we're trying to fix here, back to Bob's question what's the problem. As I read the material, it strikes me that low volume is normally an outcome of the other risk factors, but it is often the problem that we ought to address policy to. I think it confuses that by treating it as a risk factor so coincident with what may be its causes rather than similarly structured risks.

MR. PETTENGILL: I'll have to think that through a little more and see how I can sort that out. I think you're right.

DR. STOWERS: Do you have a sense of the weighting? When we talk about low volume and then we talk about weak market base or nearby competitors, my sense is that the majority of it is their market base and that the free market and the ability of small communities to support unnecessary hospitals and so forth has already done a lot of the weeding out of the two hospitals sitting beside each other.

But yet when we list them directly beside each other, it looks like they're kind of equal. Do we have a sense of that? Because I think the nearby competitor thing out there is very small compared to the low volume and other things.

Another thing is when it comes to the survival of a hospital, low volume may not entirely be the problem. I think what you're getting to, it may be higher volume but uncompensated, coming with less insurance and all of the

other things. And that kind of has to show in there, too, a little bit.

MR. PETTENGILL: I don't know what to say about that. Quite a few of those low volume providers on that low volume map are right next to each other. I think it's been kind of a common -- I don't think it's a myth, I think it's a reality for years that communities exist, they have a hospital, it's a low volume hospital that's doing badly financially. They do whatever they have to do to keep it alive, because they regard it as absolutely essential to the survival of the community.

So I don't think the market has, in fact, driven out all of the facilities that probably can't be supported by a freely operating market.

DR. STOWERS: I guess the question here comes as what's right next to each other? I mean, if there's two hospitals within five miles or 10 miles or whatever. But if there's two communities 25 miles apart or 30, then -- I just don't have a sense of what percentage are where on this proximity.

MR. PETTENGILL: I think you can figure out how the distribution of the low volume providers breaks out by distance. I think you'll find that a number of low volume providers are not far away from the next nearest hospital.

I guess the only other thing I wanted to talk about here was the next table, which is on rural hospital diversification. There's another map in here just before that that associates low volume and reliance on long-term care.

There are quite a few facilities, and this is the combination -- and by the way, the labels are switched on that map. The light gray is, in fact, the low volume providers that have 50 percent or more of their patient days as long-term care. That's shown as black.

But the point here was that one of the things that you saw in the site visit out in Montana was that some of the small town low volume providers responded to their situation by providing a lot of long-term care. Essentially, they had a nursing facility, they had a rural health clinic, they had an outpatient department, and those

1 were the main sources of their revenues, not inpatient care,
2 not swing bed care, and that sort of thing. That's how they
3 stayed alive.
4 If you look at this table on diversification, this
5 is by UIC code, you'll see a pretty clear pattern of what
6 services hospitals tend to offer according to where they
7 are. Swing beds goes way up as you go out into more and
8 more rural communities. Separate skilled nursing facilities
9 go down. The presence of a nursing facility that is not a
10 swing bed unit or a SNF goes up. The fraction of facilities
11 that are providing long-term care, any kind of long-term
12 care, goes way up. But you don't get rehabilitation units
13 and psychiatric units.
14 DR. ROWE: Julian, how do you reconcile these data
15 with the statement that comes later in one of the other
16 chapters that you make about the fact that the length of
17 stay in these smaller isolated rural hospitals may be longer
18 because they have less access to post-acute care facilities?
19 MR. PETTENGILL: I have difficulty reconciling
20 that.

DR. ROWE: Those swing beds and SNF units and long-term care units associated with these hospitals that are very small...

MR. PETTENGILL: Have long lengths of stay. I think we have to recognize that the length of stay analysis that is there in the later chapter is really at the very beginning. It's a very preliminary analysis. I'm not suggesting that the numbers will change.

But I think if you look maybe at expected length of stay, given the DRG, you might see a somewhat different picture. Or it might well be the case that length of stay is simply higher than many of these places.

DR. ROWE: It may be something, but it might be worth, in the later chapter, including some of these data because there is that paragraph or two you have about the traditional reasons for this longer length of stay, blah, blah, blah, blah. Here, at least, are some data that are relevant.

MR. PETTENGILL: I think there's certainly an issue of consistency here that we will have to address.

DR. WAKEFIELD: Two quick questions. Julian, first on the map that's labeled low volume providers and reliance on long-term care, you use Montana as an example. Are all of the dots, the black and gray on that map, do they all refer to some type of long-term care being provided by a low volume provider except that one of them has greater than 50 percent long-term care days?

MR. PETTENGILL: The light gray is low volume provider.

DR. WAKEFIELD: No long term care?

MR. PETTENGILL: It just doesn't qualify as having more than half of its patient days as long-term care.

DR. WAKEFIELD: Then what's the other one?

MR. PETTENGILL: The other one is low volume providers that have more than half their patient days as long-term care.

DR. WAKEFIELD: So they all have long-term care?

MR. PETTENGILL: No, they're all low volume.

DR. WAKEFIELD: It's all low volume.

MR. PETTENGILL: And some of them rely heavily on

long-term care.

DR. WAKEFIELD: More heavily than the others?

MR. PETTENGILL: Much more heavily, yes.

DR. WAKEFIELD: And that's what you're drawing here.

DR. REISCHAUER: But there could be some with zero.

MR. PETTENGILL: That's correct, yes.

DR. WAKEFIELD: That's what I'm asking.

The second question is on the diversification by UIC, we don't have anything on home health probably?

MR. PETTENGILL: Actually we do. I didn't put it in there because it was flat and this is an overhead.

MS. BEE: These are just hospital based.

MR. PETTENGILL: All of these are hospital based.

DR. WAKEFIELD: So my question is --

MR. PETTENGILL: I didn't include it because it was flat.

MR. SMITH: Julian, back to Jack's question for a minute, I would think in order to answer it you would have

to know something about a bed-to-population ratio, rather than simply facilities with the service. Otherwise, it doesn't tell us very much about the availability of the service if we don't have some metric that allows us to match up potential demand with potential provision. Simply facilities doesn't get to that.

MR. PETTENGILL: I wasn't thinking about this in the context of what it says about access to various kinds of services. I was thinking about it more as an indicator of how rural providers respond when they have different circumstances.

MR. SMITH: But in a very small market, one swing bed is very different from three. I'm saying that the presence of a swing bed capacity doesn't tell you very much unless you match it up with something about population.

MR. PETTENGILL: I don't know whether you could do that in a way that would be meaningful.

MR. SMITH: I was just wondering if not doing means that this data is very meaningful.

MR. PETTENGILL: I think all it tells you is that

hospitals that are located in more remote rural areas are more likely to have swing beds than --

MR. SMITH: At least one.

MR. PETTENGILL: Yes, that's true. I suppose if we had time to -- many of these maps and tables raise many more questions than they answer, that's clear. And if we had the opportunity to pursue some of this stuff, I think we could maybe find some much more interesting things. But under the circumstances, we don't have the time to do it at this moment.

We could do some follow-up work, perhaps next year, and I'm not promising to do that, but we could bring it up at the retreat.

I think it's time to go on to the use rate part of this, which is a reprise, that Dan will do.

DR. ZABINSKI: Thank you. As part of this chapter we're going to include a comparison of rural and urban beneficiaries' use of care. At the March meeting we presented preliminary results from that analysis. In the meantime, we have modified it, adding post-acute care to

beneficiaries' use and addressing commissioner's comments.

Before discussing the results from that analysis, we think it's important to mention that one should be really careful about not reading too much into use rates when you're interpreting them because they are, in some cases, rather crude indicators of potential problems.

For example, one may be tempted to conclude that lower use by rural beneficiaries indicates an access problem for them. But this would overlook other possibilities such as differences in practice patterns or beneficiaries' propensity to seek care.

Also, I think we should always be aware that use rate differences do not always indicate a similar difference in impact on health outcomes. For example, two beneficiaries using the same amount of care could have very different health outcomes because their quality of care, their need for care, and the mix of their services could be very different.

The first thing we looked at in our analysis are national average differences in urban and rural

beneficiaries' use rates. We grouped the beneficiaries into six categories using the same five rural categories that Julian had on his diagrams and added an urban group.

On this diagram we have the ruralness of beneficiaries' groups along the horizontal axis. On the very left column we have the metropolitan or urban group. As you move to the right, you get to more progressively rural groups.

The vertical bars indicate average use for each group.

DR. NEWHOUSE: Are those dollars?

DR. WILENSKY: It would be nice to have something on the axis to give us some idea.

DR. ZABINSKI: It's sort of an index of use. What we're measuring basically is like the amount of care that the beneficiaries would have as measured if Medicare used national payment rates, basically.

DR. NEWHOUSE: I think you need to put in the units, when you do this for real -- when it goes on Broadway.

DR. ROWE: Explain to me, what's striking here is the lack of a difference. This is one of the themes from the last meeting, that many of the places we expected to see a difference, the differences more modest or non-existent. But it's not clear to me that the way you did this you couldn't have shown a difference if you wanted to.

So what exactly is the amount of care? Is this per person?

DR. ZABINSKI: This is per beneficiary, right.

DR. ROWE: Medicare beneficiary.

DR. ZABINSKI: Per Medicare beneficiary.

DR. ROWE: And this is some unit of hospitalization, doctor visits, home care visits, some mixture?

DR. ZABINSKI: Typically what we did was this. Let's use physician care as an example. We would take the relative value units for each physician unit and multiply it by the national adjustment factor. And then we did the same sort of thing for hospital inpatient using DRGs, hospital outpatient care using value units, and so forth.

DR. NEWHOUSE: It's units of service weighted by the same prices for everybody.

DR. ROWE: That's great. Would it be fair that if we assumed that the degree of illness or sickness or care need is the same across the country -- I'm sure that's not the case, but let's just stipulate that -- that in fact, therefore, the health care needs of people across the country are being rather equally -- I'm not saying adequately, they may only be getting 70 percent of what they need -- but equally addressed, irrespective of whether they are in an urban or rural setting? Is that what this says?

DR. ZABINSKI: I would say that use is about the same in rural and urban settings. But as far as health care needs, addressing that point Jack, as you see here we have for each ruralness category you have two sets of bars. The wider one on the left indicates a raw use rate. The one on the right indicates adjusted for health status differences between groups.

But adjusting for health status doesn't really change the qualitative analysis here of use rates really

1 don't look much different.

2 DR. WILENSKY: They don't look much different,

3 even unadjusted.

4 DR. NEWHOUSE: And the adjustment is actually

5 imperfect, so if anything it looks like the rural use, if

6 anything, may be greater because the urban group is sicker

7 because of the missing HMO group. I think the sameness or

8 the lack of a big difference is the important point.

9 MS. ROSENBLATT: I have a question on this now

10 that I understand the mathematics of it. If it's weighted

11 by dollars, the hospital DRG dollars are going to be really

12 dominant in the total. And therefore, if there's a very

13 slight difference in the hospital usage, that's going to

14 drive the similarity --

15 DR. REISCHAUER: Makes rural use look a lot

16 greater.

17 MS. BEE: As we work through the analysis, we've

18 also included some detail on the composition of services

19 within that bar. Indeed, that bar is the total of

20 inpatient, outpatient, physician, rural health clinic, and

all post-acute settings. And we'll break that out to see how the composition of that varies.

DR. ROWE: This really gets to, just for the record because we discussed this earlier, the celebratory nature of at least some of what these data suggest, and that is that assuming that we started at a place where there was greater disadvantage in rural, with respect to access to care, this would appear to address the question of access and say that, at this point at least, there are not very substantial systematic deficiencies by category. There may be individuals or individual markets, et cetera. But at least by category of ruralness, with respect to the amount of care that's being delivered.

DR. WILENSKY: Use, not access. Access is somewhat more complicated. But at least in terms of observed use, it looks very comparable, given the measures that are shown here.

DR. REISCHAUER: Just to elaborate on Alice's point, to come to a conclusion totally different from Jack's, folks in rural areas don't see physicians as often,

1 don't get the same kind of preventive care, end up in the
2 hospital more, and then we celebrate it. This is a
3 hypothesis.
4 DR. ZABINSKI: There is one difference and it's
5 actually coming up in the later slide. Urban beneficiaries
6 do use quite a bit more physician services and rural
7 beneficiaries do have a fair amount more hospital inpatient
8 care.
9 DR. WILENSKY: Again, I think this is a useful way
10 to look at an aggregate cut at what is going on, and then
11 you need to back up and talk about what's lying underneath
12 it. But I do think it's important, in the places where we
13 see more comparable use than we might have expected, to
14 point that out. And in the places where we see differential
15 use, as in terms of physician care or home care or the mix
16 between skilled nursing facility and home care, that we make
17 those comments, as well.
18 DR. ZABINSKI: Before we move on from the slide,
19 there's one thing I'd like to point out, though. This
20 diagram includes only fee-for-service beneficiaries. It

excludes Medicare+Choice. In particular metropolitan areas that's an important group. It encompasses about 21 percent of that population. So if you included Medicare+Choice in this, the relationship might change some because they're typically healthier than that.

But the data for those people don't exist, in terms of claims data, so we really can't include them.

DR. WILENSKY: I assume in the final chapter, that would be included on the chart? You want to have, if somebody picks up this chart, there's a footnote at the bottom that says excludes HMO enrollees.

DR. NEWHOUSE: That's a really important caveat.

DR. ZABINSKI: Yes.

DR. ROWE: But what you're saying, Dan, if I understand, and I think this is important, is that that might be the case with respect to the light bar, but the darker bar --

DR. NEWHOUSE: No.

DR. WILENSKY: No.

DR. ROWE: --which corrects for health status,

since the Medicare+Choice people are healthier, there would be a correction there vis-a-vis their health status that might compensate for the change.

DR. NEWHOUSE: Not enough.

DR. ZABINSKI: It's an imperfect correction, though.

DR. ROWE: What would it show, do you think, if you then put in the Medicare+Choice population?

DR. NEWHOUSE: Drop the metropolitan.

DR. WILENSKY: Drop the metropolitan.

DR. ROWE: Exactly. It would make the rural look like it was getting more, even though it may be different categories of care.

How much substitution is there, to get to Professor Reischauer's excellent point? Is there some change in the finances so that it's not all just dollars, so that if somebody doesn't get to the doctor and therefore they wind up in the hospital and that is obviously more expensive to it's more use, is there any substitution metric here?

DR. NEWHOUSE: Right. That's what we need to say.

DR. ZABINSKI: No.

MR. PETTENGILL: If they show up, if they go to the hospital and they're more seriously ill so they end up in a more expensive DRG, that would be included. But if they went and they were more seriously ill but ended up in the same DRG, coronary bypass say, but they were more likely to have complications and result in outlier payments, that wouldn't be here.

DR. ROWE: But if they don't get a flu shot because they don't get to the doctor, and they get influenza and they get in the hospital, it looks like they used more health care.

MR. PETTENGILL: That's right.

DR. ROWE: And they had the same health status going in. That's the point.

DR. WILENSKY: They do use more health care.

DR. ROWE: If they don't get influenza, because you have to catch it from someone, then they're apparently living in a place where there's no one else.

[Laughter.]

MS. ROSENBLATT: How did you risk adjust it down?

DR. ZABINSKI: I used the risk factors from the HGC, the hierarchical condition category model.

MS. ROSENBLATT: You're using inpatient and outpatient?

DR. ZABINSKI: Yes.

MS. ROSENBLATT: And it's a single weighted DRG, that dollar value? You're not doing this DRG by DRG in hospitals?

DR. ZABINSKI: Yes.

MS. ROSENBLATT: You are doing it DRG by DRG.

DR. ZABINSKI: Somebody has an inpatient stay, we take the DRG weight and multiply it by a national adjustment factor.

MS. ROSENBLATT: And the unadjusted, if there are more people going to the more severe DRGs in the metropolitan area, that would cause the metropolitan weight to be higher?

DR. ZABINSKI: It would raise the metropolitan use.

We also looked at this on a region by region basis, as well. When we've looked at the beneficiaries in the regions, we continue to find small urban and rural differences in the adjusted use rates within regions. However, we did find that overall use is fairly different between regions.

In this diagram, once again we separate the beneficiaries into four regions. Once again, the light bars indicate the unadjusted use rate, and the darker bars indicate adjusted for health status.

I'd like you to focus on the West and the South, that is the second set of bars and the final set of bars on the right. The South is higher and the West is lower. For example, the adjusted use rate in the South is about 15 percent higher than what it is in the West.

DR. WAKEFIELD: This is just rural?

DR. ZABINSKI: No. This is everybody together.

DR. WAKEFIELD: Everyone in that region.

DR. ZABINSKI: Yes, this is urban and rural together, everybody in the region. So the overall use rate in the South is higher than what it is in the West.

As we already discussed, though, one important discrepancy that we have here between urban and rural is that the mix of service is quite different. As I said, urban beneficiaries use more physician care and, to a lesser extent, more post-acute care services. Conversely, rural beneficiaries use more hospital inpatient and hospital outpatient services.

DR. ROWE: Can you give us some quantitative measure of what you mean by more?

DR. ZABINSKI: Physician, in the neighborhood of about 15 percent more in urban areas.

DR. ROWE: 15, 1-5?

DR. ZABINSKI: 15. Post-acute care not quite so. It was about 8 or 9 percent. Hospital inpatient care, 7 or 8 percent higher in rural areas. Hospital outpatient, it's more extreme, probably in the neighborhood of 10 to 12 percent, I'd say.

DR. ROWE: But if you add -- so hospital outpatient use is less or more?

DR. ZABINSKI: It's more in rural areas.

DR. ROWE: Because if you add that together with the physician visits in the community, since there might be fewer physicians --

DR. NEWHOUSE: And the rural clinics.

DR. ROWE: What do you wind up with?

DR. ZABINSKI: Pretty flat.

We also try to address some concerns that the commissioners raised at the March meeting. First, we examine variation in use to see if rural counties are more likely to have either very high use rates or very low use rates. For each county we compared per capita use to the national average. And we found that rural beneficiaries are both much more likely to live in counties with very high use rates, as well as very low use rates.

DR. NEWHOUSE: Dan, is this on a year?

DR. ZABINSKI: Yes.

DR. NEWHOUSE: I think you need to make a

technical correction here. Since this is going to be interpreted as some kind of steady state behavior, I think you need to correct for number of lives. Just on random variation, rural will bounce around more than urban.

DR. ZABINSKI: We tried to do that. For example, what we did -- okay, we calculated a standard deviation of the use rates across counties and then we calculated an 80 percent competence interval for each county's use rates using that standard deviation. But if a county had fewer than 30 people, we used the adjustment factor from the student T distribution that applies to the size of the --

DR. NEWHOUSE: You can actually make a fix right on the number of people. We can talk about it afterwards.

DR. ROWE: Can we go back to a second to the prior slide. I just want to make sure -- it says urban use more physician services and you just told me that if you add up the physicians in the community and the physicians in the outpatient and the clinics it's the same.

DR. ZABINSKI: No, the physician services are just physician services. It doesn't matter where they are. They

all go. If physician care takes place in an outpatient unit, it goes into the physician category, but just those services that the physician supplied.

DR. NEWHOUSE: How about the rural health clinic?

DR. ZABINSKI: The rural health clinic, we use it as a separate category in the total, but when you add the rural health clinic to the physician care it closes the gap.

DR. ROWE: So we should get the data before we make this final statement here?

DR. ZABINSKI: No, I think the statement is correct. All physician services are put into the physician category. It doesn't matter whether they're in a physician office, some sort of inpatient care.

DR. NEWHOUSE: But the equivalent of the outpatient department facility fee is in the physician component for when you go to the office, and it's not in it when you go to the outpatient department. I think that's Jack's point.

DR. ROWE: That's my point.

DR. NEWHOUSE: I think Jack wants basically

outpatient services, as opposed to physician services.

DR. ROWE: Yes, because the patient is seeing a doctor, the fact that there's a global fee rather than a physician and a facility fee and it doesn't show up as a physician service. And it is, we're talking about doctors seeing patients. And this, for the non-cognoscenti, that might potentially be misleading.

MS. RAPHAEL: I just want to clarify the post-acute because I think we are getting contrary information here. For home health care, I think I remember there were more visits per beneficiary in the rural areas. So that would mean that in that center, at least, the post-acute, the rural use is higher.

I don't know what it is on the SNF side and we were asking questions before that how best to measure it.

MS. BEE: The observed use is both the use per beneficiary and the volume per user. And so one of the aspects that makes home health flat is that though we have fewer users per beneficiary, rural beneficiaries use more services. And so that tends to flatten out the total home

health use between urban and rural.

So when we talk about use, it's the conjunction of those two influences.

DR. ROWE: Is that consistent with this statement, that urban use more post-acute services?

MS. BEE: We have a picture for you.

DR. WILENSKY: I think the answer is, yes, this slide is correct but it's because of in the rural areas you have a lower likelihood of use, and once you use you have a high use rate.

MS. BEE: Right.

DR. WAKEFIELD: Maybe this is drawing a distinction that you're not so interested in, but isn't it also the case that it's a higher number of visits, but the amount of therapies that are provided to rural beneficiaries is markedly lower than those therapies provided to their urban beneficiary counterparts? That's an important distinction, I think.

MS. BEE: Right. That's part of what our wizardry is trying to get at. By trying to value these all at a

constant dollar, we've managed to capture that therapy is a little bit more complex and a little bit more intense than an aide or a skilled nursing care. So hopefully by standardizing that, we've captured that.

DR. ROWE: What's the specialty hospital?

MS. BEE: In this slide, it's long-term care and rehab. We've also measured psych but we've included that as an acute service, rather than a post-acute.

DR. WILENSKY: Again, don't forget that we have a special chapter that looks at home care so that we go into more detail, specifically about the difference in therapy use. And that what we're trying to do here is present an overall view of what is going on.

DR. WAKEFIELD: Right. Just my only question is, back to that national use rates, and the fact that that reflects a lot of stuff going on in that one chart, and how it could be interpreted.

DR. WILENSKY: If you have a single summary chart, that's the nature of what you're doing.

DR. WAKEFIELD: It needs to be described in the

narrative.

DR. ZABINSKI: Also when we look at variation in use, we've tried to separate the high use counties from the low use counties. In this diagram, the dark green marks, although they're not as distinct as I would have liked, but the darker green marks indicate high use counties. The lighter green marks indicate low use counties.

Not surprising, you get a pretty high concentration of high use in Louisiana, but also Mississippi and Texas. The low use counties are somewhat spread throughout the Great Plains and the Rocky Mountain states in the West.

DR. STOWERS: Is this use per beneficiary?

DR. ZABINSKI: Yes.

DR. STOWERS: Because that would be very important because several of these are very remote counties that may have 200, 300 people in them. And yet they're a high use county.

MR. PETTENGILL: The intent here was not to say, this is a problematic county, it's definitely high use off

the scale or low use off the scale. It's that these are places that if you were looking -- it was to try to get to Mary's point from last time, where she was saying can't we see something about the diversity, how much variation there is.

These are the extremes. Now they may or may not be problems. You'd have to look further to know that.

DR. NEWHOUSE: But I don't think we want to take account of just random variation that bounces around from year to year. Maybe that was what Mary wanted, but I think that's misleading. If you had one big case in a county with 200 beneficiaries, so what?

DR. WAKEFIELD: No, I wasn't interested in random variation. It was trying to tease out -- what I think the staff has done actually the best job they could in the time that they had, and that is to try and break down the information as discretely as possible to try to not move back from all rural and label all rural with one diagnosis, and instead to really try to tease out to get a better understanding of where are the problem areas and then

address policy solutions to those particular areas. That was the driver.

DR. WILENSKY: Julian, I think the attention that you'll face, and Dan also, in what you've got in terms of your discussion, is this balance between trying to aggregate so that people can get an overall message, which I think is important and you've done, and indicate the but underlying an aggregate similarity are important differences that build to that aggregate. And you're going to have to look to the later chapters to decide whether those differences reflect different ways that services are going to be provided for a whole series of reasons -- some geographic, some historical, some economic -- and whether they're appropriate or inappropriate differences.

But it's going to be this tension of you want to pull together. That is the point of this chapter, to kind of get an overview of what's going on, but to indicate thereafter to the extent that there are important differences like the overall use rate, but differences in terms of what's made up, and just reference this discussion

later. So that you provide early on a reference point to later parts of the volume, and also remind people even early on that what looks similar has important component differences which they may or may not decide ought to have a policy associated with it.

I don't want you to have the takeaway message to back off from these aggregate statements. It's very important we try to look at what it looks like when you take the different measures that are talked about later in the volume and put them all together, what does it look like? And the same with the various adjustments.

It's the best way to try to get an overall view, and then we can go through the differences.

MR. PETTENGILL: We were just seeking to find the balance ourselves between the overall conclusion and not be telling people that it's the same everywhere. It isn't the same.

DR. WILENSKY: The other issue that you're going to need to try to balance in the discussion is the area in which Medicare is the appropriate policy instrument in the

area when there is a problem that is viewed or there's an issue that's viewed as problematic, that there may be areas of policy that are not appropriate to Medicare, even though they're appropriate to intervention.

Having that theme so that you can lay it out first and then, as we go through the later chapters, either that you can point to or that later chapters can point back to. So that either in the summary statements to the individual chapter or in the overview chapter or in the executive summary, someone is going to need to pull this together. Here are the areas where we think Medicare is the appropriate instrument by refining how we calculate cost differences or make other changes in payment. And then there may be other areas that are appropriate for intervention but they're not Medicare issues or they're not issues that Medicare is likely to impact in a meaningful way. And therefore, to the extent that they're regarded as important policy issues, we'll have to look for another tool.

I think this chapter, it's not the executive

summary, which will have an important role to fill, but you ought to be leading the way with what will come and hopefully have some references back in the later chapters to what went on here.

MR. PETTENGILL: We'll try to do that.

MR. SMITH: Along the same lines, Julian, it seems to me important to be clear where we can that revealing a difference doesn't reveal a problem, and some of the discussion that we tried to have about the effect of substitution for outpatient visits for physician visits, that it reveals a difference but it may not reveal a problem. We're not sure.

There will be a tendency to consume this report and focus on differences and to find differences as problems and where we're not sure that differences explain problems it seems to me important to point that out.

DR. REISCHAUER: On the same token, a lack of difference doesn't mean a lack of problem.

MR. SMITH: Right.

DR. LOOP: I was just taking some notes. I think

this is a good introductory chapter. The objective, if we can just talk about fundamentals for a minute, the objective here of all of these chapters is to try to help the rural beneficiary that truly needs help. And as a secondary objective, help the rural hospitals that are truly in need. It seems to me that's what we're trying to do here.

I think the goal is made a lot more difficult by the raw definition of rural hospitals. You've got 40 percent of the hospitals in the United States are classified as rural and yet only 20 percent of the population is considered rural. And so the problems of the really rural hospitals, at the end of the spectrum of ruralness and also as defined by some of your risk factors, is diluted by the data from the more urban rural hospitals.

I think this is also complicated by the fact that there's this Brownian movement of reclassification of hospitals.

Now I may be in an area where politics are going to be so strong that you'll never be able to influence policy, but I think the best thing that this commission

1 could do is try to redefine ruralness and make the
2 definition of rural hospitals more explicit in the areas
3 that are truly in need.
4 MR. PETTENGILL: That's pretty ambitious.
5 DR. WILENSKY: I think the point is well taken.
6 To the extent we can at least raise the issue at this point,
7 some of which is done in the UIC discussion and other
8 discussions earlier, it would be very helpful. Again, as we
9 proceed, when we do the hospital payment chapter through
10 some of the other chapters, to try to raise this more
11 explicitly, that the definitions have a highly political
12 tinge or tone to them is something we're not going to be
13 able to deal with. But I think to the point that we think
14 there are important differences that suggest differential
15 policy responses, we certainly ought to say that.
16 And I don't know how much you feel like you can
17 inform this issue more than what's already in here, but I
18 think it's a good point.
19 DR. LOOP: The definition, the way it is now. may
20 prevent us from getting to the root of the problem.

MR. PETTENGILL: I don't know that it does. My sense is we're classifying as rural here hospitals that are actually physically located in a non-metropolitan county. In other words, we're not counting somebody as urban if they were reclassified to an urban area for the purpose of the wage index. So that's not an issue.

I think what the UIC code classification does for us basically is it sorts out the hospitals that tend to be larger, serving a larger population, and counties that area adjacent. Or even counties that are not, where they're in a town that's greater than 10,000.

That distinction, based on town size, I think is probably the one you want to make, compared to the hospitals serving more remote rural areas where the population is really small.

We can't do that perfectly, but I think we can sort it out enough to make it clear to people that these facilities are different and the conditions they face are different and the policy solutions may well have to be different.

MR. HACKBARTH: The fact that you have a higher proportion of hospitals being labeled rural, as opposed to percentage of the population being labeled rural, isn't that the byproduct of rural hospitals being smaller?

DR. WILENSKY: Yes.

VOICE: It's beds we should be counting.

MR. HACKBARTH: So to me, Floyd, that doesn't necessarily signify that we've got some not really rural hospitals classified as rural. It's just an artifact of the size of the hospitals.

DR. WILENSKY: But the general point is worth making, that sometimes what we classify is done for political reasons rather than other reasons. But to the extent that you've not included those in your discussions is helpful.

Any other comments?

MR. DeBUSK: I'm here in Section D, when we get into improving payments for inpatient hospital care in rural areas, then you run into a whole new classification.

DR. WILENSKY: Why don't we wait with that. We

will be spending almost two hours on that section this afternoon.

MR. DeBUSK: But then you put all that in with this and then the confusion gets even greater.

MR. SMITH: You've made the point several times that size is more important than adjacency. And you added three and five together. I wondered why you left seven out?

MS. BEE: Because someone in UIC seven could have a city right up to the MSA limit. So conceivably some cities within a seven UIC could be quite large. so we found that seven acted like adjacent counties with large cities more than it acted like either --

MR. SMITH: like isolated counties.

MS. BEE: -- with small cities.

DR. WILENSKY: Pete, did you want to raise something with regard to this chapter, as opposed to the chapter that's coming? We'll have a very long discussion on the payments.

MR. DeBUSK: No, I understand what you're trying to say. I think the game begins when we get to that section

about what's the reality of trying to classify all this stuff.

DR. WILENSKY: Okay, thank you. Commissioners who have individual comments to suggest to Julian on this chapter, please contact him and give him your comments on your written chapter drafts.

Mary? We know you're here without your co-authors, one of whom is imminently waiting to hatch, we understand.

DR. MAZANEC: It's very lonely at this table today.

We have significantly revised the chapter on quality of care to reflect the Commission's comments at the March meeting. We tried to refocus the chapter to emphasize the needs of the beneficiary.

Medicare's primary goal is to ensure that its beneficiaries have access to medically necessary care of high quality. Recent evidence suggests that the provision of necessary ambulatory care is roughly comparable between rural and urban beneficiaries.

Although differences in the receipt of necessary care appear to be modest, beneficiaries residing in remote rural areas, including HPSAs, are less likely to receive necessary ambulatory care compared with beneficiaries residing elsewhere.

While the delivery of necessary ambulatory care to rural beneficiaries appears to be roughly comparable to urban beneficiaries, differences exist in the clinical outcomes of beneficiaries who receive care from small inpatient providers located both in rural and urban areas, as compared with larger providers.

In your mailing materials, we also reviewed beneficiary satisfaction with care. In general, rural beneficiaries report being satisfied with their care, although they have more difficulty in actually getting to sites of care.

Recent MedPAC analyses have demonstrated that opportunities exist to improve the quality of care furnished to both rural and urban beneficiaries. This may involve broadening the measures of clinical performance and outcomes

data that are collected. Medicare should develop systems that regularly monitor the quality of care furnished to beneficiaries residing in rural areas.

Data we presented in the paper suggests continued need for quality improvement efforts to improve care across rural areas. Under the previous contract for the peer review organizations, QI activities have improved the quality of care among certain providers in rural areas. For example, as noted in your mailing materials, treatment of acute MI patients with aspirin or thrombolytics improved following a PRO initiative.

This brings us to our first draft recommendation. MedPAC recommends including rural populations on the list of population groups that the peer review organizations must consider in carrying out their quality improvement activities.

Medicare sets participation standards for health care providers to ensure a minimum standard for quality and safety of care furnished to its beneficiaries. Under current funding and legal requirements, most facilities are

1 surveyed relatively infrequently. In addition, rural
2 providers face fewer incentives to seek private
3 accreditation compared with their urban counterparts.
4 This leads us to the second draft recommendation.
5 MedPAC reiterates its recommendation made in June of 2000
6 that the Congress should require the Secretary to survey at
7 least one-third of each facility type annually to certify
8 compliance with the conditions of participation.
9 I'm going to stop here and open this chapter up
10 for comment.
11
12 MR. DeBUSK: The first draft recommendation,
13 MedPAC recommends that the Secretary require the peer review
14 organizations to include rural populations in the groups
15 that they consider in carrying out their quality improvement
16 activities. What does that mean?
17 DR. MAZANEC: What we wanted to do is to try to
18 encourage PROs to look at rural sites of care in some of
19 their activities, in some of their quality improvement
20 activities or studies that they have. That does not mean,

as stated in the chapter, that we want rural populations to be designated as the equivalent of a minority group or an ethnic group, but we wanted to somehow support PRO activities in rural areas more than what we are currently seeing.

MR. DeBUSK: You look at this and what is the approach? That's one major area in rural facilities that I think there's a lot lacking, in getting to the patient faster, taking care of the patient, providing the proper care, and what have you, the access, quality and all comes into play right here.

A lot of this just seems like words. And maybe that's all we can do, but it looks like there should be some way that we can do more than just pass the football.

MR. HACKBARTH: As I recall from the chapter, the problem that we're trying to address is that the current scope of work has a metric that biases the PROs towards focusing on high population areas. That's where their rewards are.

Basically, we're recommending simply that the new

scope of work not have that bias towards high population but that we specifically carve out some resources for improving quality in rural areas without trying to micromanage the Secretary and how they write the scope of work.

DR. NEWHOUSE: I'll take my prerogative as temporary chair. This is actually for people to shoot at, because I'm not sure how I come down on it. But in light of the previous discussion of the diversity among rural areas, is this potentially overly broad? Or should we point toward where we think problems are more likely to be?

MS. NEWPORT: I was feeling the same way, Joe. This may be too broad. Just based on experience in M+C, where the quality measurement standards start out with four, then eight. And you need to have clinically, I understand from talking to my medical directors, you need to have a trend that you can monitor to improvement and reasonable improvement. And that the pylon at HCFA, in terms of increasing the standards and 10 percent improvement per year, which is impossible after a while.

So I would like to see this moderated in terms of

appropriateness, in terms of burden, two or three areas recommended. Let's say diabetes control, coronary issues, something like that, and build on that and have them symmetrical enough or identical enough that they can be implemented and then trended and then looked at in terms of okay, where can we go next?

So while the PROs may choose to carry it out slightly differently, at least the providers that are going to be measured for quality will have apples to apples as much as possible.

I think that if we kind of align ourselves around something like that, it should be right sized for the size of the providers in the community, so that's implementable, measurable, and it has some meaning over time.

DR. LOOP: Picking up on that last comment, I think if we want to debride some of HCFA's responsibilities, we ought to let the Joint Commission assess quality.

But let me make a couple of points about this chapter.

DR. ROWE: Or NCQA or somebody else.

DR. LOOP: Yes. The first sentence under key points, that a large gap exists between the care they should receive and the care they do receive, I think probably care is not optimal. As you get down into deeper and deeper into ruralness that's probably true.

But over here on page four, near the end of the page, you say that remote rural areas are 2.5 percent less likely to receive clinically appropriate care compared with beneficiaries residing in metropolitan counties. Is that a lot? Is that a little? Does that also mean metropolitan counties don't get very good care either, compared to what they should have?

I think we have to clean up some of that because it sends a bad message out which is highly subjective and not necessarily true, I don't believe.

DR. WAKEFIELD: Just a couple of comments, first if I could on the chapter. I think that when this gets written, if there was a way of speaking maybe a little bit more to -- the chapter starts out talking about standards, I think, and whether rural areas meet the same standards,

should they meet the same standards, et cetera, as urban areas do. And how do you measure that anyway, if it's beta blocker usage or whatever?

But I think that later in the chapter, but at least as important a point, is first we need standardized ways of getting information. In some instances, rural hospitals are at, I think, a disadvantage for collecting information. So before you set the standards, how are we going to get there? What are the standardized ways we're all going to agree on that will be collecting that information?

You get into it a little bit toward the end, I think, when you're talking about performance indicators, et cetera. But maybe that could be beefed up, because I think that is a challenge.

Related to that, part of that data collection also, I think, speaks to the availability of things like electronic medical records and other IT infrastructure, et cetera. So those two issues are not completely divorced. They don't have that infrastructure. It's really difficult

1 to collect standardized information on the extent to which
2 they're meeting standards.
3 So it's maybe trying to put a little bit more of
4 that spin into it because I think that's an important
5 challenge to highlight.
6 Related to the recommendation, I didn't have a
7 problem with this recommendation. I actually thought it was
8 a good one. I don't have a problem with targeting it
9 further the way perhaps that's been suggested here. So that
10 we really make sure that the PROs are providing a QI assist
11 to those rural areas that might need it the most.
12 But I would say that last time we discussed this
13 draft, and I believe it's still in here, you talk about I
14 think the disincentives to PROs to reach out to rural
15 providers. I think what we're trying to do is moderate that
16 disincentive a little bit, particularly given that we've got
17 lots of hospitals out there who are not JCAHO accredited,
18 for example, who rely on state survey and cert processes.
19 So we've got a disincentive I think we're trying
20 to moderate. And we've got probably a QI infrastructure

1 somewhere in South Dakota that doesn't look like Beth
2 Israel's QI infrastructure. So I think there's a legitimate
3 need in a lot of cases, and I think that we ought to be
4 trying to moderate a little bit that disincentive the PROs
5 are probably currently under.
6 DR. NELSON: My comments were along a similar
7 vein. Mary replied to, I think Pete's question, that draft
8 recommendation one -- and you use the word encourage, the
9 Secretary encourage the peer review organizations to include
10 rural populations.
11 I think it would be a big mistake for us to try
12 and rewrite the PROs scope of work for them. I think we
13 have to acknowledge that the Utah PRO has a different kind
14 of capability than say a PRO in a rural area in Florida
15 might have, for example.
16 I think it's entirely appropriate to recommend
17 that the Secretary encourage more attention to quality
18 assurance in the rural areas, but that can be done through
19 providing adequate funding for the PROs to do this kind of
20 thing. I would prefer to stay away from the word require

and substitute instead the word encourage.

DR. WILENSKY: We'll come back and let's have a specific discussion and do a vote on the recommendation when we're through with this discussion.

MR. HACKBARTH: I was just going to second the point that Floyd had made about the use of appropriate services. To me, the striking thing is that urban or rural alike are only getting the appropriate services 73 percent of the time. Then the differences between urban and rural in that context seem quite small. Even the difference between the urban and the remote rural of 2.5 percent seems quite small compared to 73 percent versus 100.

So the news here, to me, is the similarity between urban and rural and the fact that everybody is getting only 73 percent of what the measures say they need.

DR. STOWERS: I think what I wanted to say is kind of echoing that too. An example of that is the bullet points on page 12, where we talk about the Western states having the success of raising from 40 percent to 75 percent on pneumococcal, for example.

I think it would be very nice to demonstrate what the national numbers are. Maybe not necessarily even urban versus rural, but if we're going -- to kind of put that into perspective. Because I couldn't agree more that the 70 percent to 100 percent is a lot bigger difference than maybe what the difference is otherwise.

Because the numbers nationally on these things do not look very well. And so to say that they were not very good in these particular rural areas misses the point that nationally they're terrible.

DR. REISCHAUER: We have a trade-off here really between equity and efficiency. And if the differences between rural and urban aren't very great, by suggesting that more resources should be devoted to rural, we're basically saying that overall the bang from the buck that we're going to get in improving quality is probably less after our recommendation than before.

And I think that's fine, if we think that equity deserves more emphasis than it's received in the past. But we're making it out as if the PROs have been greedily

1 focusing on urban areas for their own interest, as opposed
2 to by focusing there they might be affecting the quality of
3 care received by the most number of people per buck spent.
4 So it's a complicated kind of issue and I don't
5 think we should -- I think we should say a little more about
6 that trade-off.
7 DR. NEWHOUSE: I agree with Bob's last point,
8 although the right answer surely can't be to spend it all on
9 the urban areas.
10 But I was going to a different word, that I hadn't
11 really noticed until lately, which is that the peer review
12 organizations include rural populations. Don't you mean
13 rural providers? Do you mean populations or providers?
14 Insofar, for example, as the Nebraska PRO incentive is to
15 focus on Omaha and Lincoln, that would pick up all the rural
16 populations and filter into Omaha and Lincoln.
17 DR. MAZANEC: Maybe the more correct way to word
18 the recommendation is use the term provider, but I think
19 that we definitely wanted to put emphasis on the
20 beneficiary, also. But since the QI activities actually

1 involve the providers, maybe it's more correct to say --

2 DR. NEWHOUSE: And the incentives that are being

3 talked about go to providers, not to populations. Let me

4 suggest some wording. This is a separate point or a

5 separable point. Include those rural providers where there

6 is a pattern of care suggestive of lower quality, or

7 something of that nature, as opposed to just -- this is

8 again in the spirit of getting somewhat more targeting, and

9 also responding to the notion that we'd like them to use a

10 pattern of care rather than individual incidents.

11 MR. HACKBARTH: I like that addition, Joe. I

12 think that would be good. I wrestled with Bob's point,

13 which I think is very well taken. On the one hand, we're

14 saying there aren't many differences. Then on the other

15 hand we're saying devote more resources to rural. There is

16 some tension between those two positions.

17 The way I came down on that was if you followed

18 the logic to its conclusion, you could spend all of the

19 money in the urban areas and never have them go outside the

20 most urbanized areas. I don't think that that would be a

1 good outcome.

2 So I want to tilt it a little bit in favor of the

3 rurals and have some reward for PROs to focus on particular

4 clinical problems where there's some evidence of a potential

5 problem. I like Joe's wording.

6 DR. WILENSKY: Let me make two suggestions, one

7 procedural in a minute, and a second comment. In discussing

8 the quality issues, there seems to be a flavor that underuse

9 is the only quality problem and that inappropriate use and

10 overuse are equally problematic. And while we may not have

11 anything to offer on that work of Mark Chassen and others,

12 documenting the kinds of problems, overuse of antibiotics,

13 et cetera, it seems to send a very bad flavor in my mind,

14 that this is the only thing that we worry about as a quality

15 problem, underuse of services.

16 It's clearly not consistent with what we've done

17 elsewhere, other volumes, last year's treatment of quality

18 in a MedPAC report.

19 Why don't we turn specifically to recommendation

20 one and then recommendation two, so we can make some

modifications?

The issue, as I understand it, is that under the current contracting requirements in the PROs, there is a disincentive to include rural providers because of the weighting issue. And so it strikes me that if we want to see a greater likelihood that rural providers will be included as targets, that we're going to have to do something like this recommendation, or we ought to expect that that won't happen.

Now there are two types of changes we can consider. I found that a pretty innocuous recommendation, but we can target it more. We can indicate either in the recommendation, or we can indicate it in the paragraph that follows the recommendation that we think it needs to be targeted to providers and clinical settings where there's some indication of clinical problems. I don't know that we necessary have to put that in the recommendation.

I read the point of this recommendation is absent some change we set up a system where we ought to expect PROs will target where they get the biggest bang for their buck,

and that is in the urban areas with the higher concentration. So this is to say, again, appropriately not included here, that we don't want this at the expense of consideration of a focus on minority issues.

But it struck me as either we make a recommendation of this nature or we ought to assume that there won't continue to be not much focus on the rural areas by the activities of the PRO. Rural providers. It ought to be rural providers in there.

DR. BRAUN: I liked the recommendation also. Although it's obvious, I wonder if we shouldn't add assure provision of adequate resources because it will be more expensive and perhaps that needs to be said up front.

DR. WILENSKY: At the immediate time, that really goes after the second recommendation, which has to do with the frequency. It isn't necessarily on this recommendation that it's more expensive. This is really just saying if you include a factor which will re-weight the groups that they consider in deciding which of the group to sample.

So I think you could do this without having more

resources, but our second recommendation, which reiterates we want to see facilities surveyed once every three years, requires an adequate resource base. So I'd rather, we can either do that as a recommendation or in the discussion that follows.

DR. BRAUN: So it's assumed that here the reason they haven't done it is because of numbers?

DR. WILENSKY: No, it was assumed because of how they're going to be judged. The judging, in terms of what they are directed to do, encourages them to look to the places where they'll get the most bang for their buck.

DR. BRAUN: The most bang for the buck but that's why I'm wondering, they don't need more bucks if they're not going to get more bang.

DR. WILENSKY: It's really a question of going where you get the greatest concentration. The greater concentration is in the urban areas. So I think you can bring up the rural into the relevant pot by making this recommendation, but not necessarily have more done. I think the more done follows our second recommendation.

DR. ROWE: The way to do this would be not in a recommendation, but to try to say to the PROs that if you have a rural community within your jurisdiction, then in some proportionate way we want your resources spent on that, 10 percent of them, 15 percent of them, 20 percent, whatever it is. That would be the way to do it, rather than on the number of doctors that you've reached or number of patients that have been influenced.

DR. WILENSKY: Again, I think what we are seeing here is an attempt to include it in a direct way into the pot of providers that they have to review, to make this an explicit group within the group that they have to review. I think this does this in a very general way.

Now, there is a big difference between requiring and encourage. I personally think if we're serious, then we ought to say this has to be one of the groups that require is appropriate. We can obviously use words encourage, but the problem is that under contractual language, it's laid out so that it pushes PROs in a particular definition. And if we want to change that probability, then we have to

include a different listing within that, and we ought to acknowledge that this will require, when they come up for the next contract review, the language will be written differently.

What I'd like you to do now, in terms of moving this along, is we can either do a vote now on this, or if you have specifics of an alternative wording that you'd like to suggest, rather than this language, put that up so we can do a vote and move on.

DR. LOOP: To include rural providers and then take out in the groups that they consider. Say include rural providers in carrying out their quality improvement activities.

MS. RAPHAEL: I just wanted to step back for a moment and make sure that the recommendations that we're putting forth here, in fact, address the issues that we've raised. I'm just worried that this is a fairly innocuous recommendation in the sense that we identify the gap between what care people should receive and what they are receiving. And we also noted that people who reside in remote rural

areas and go to low volume hospitals tend to have poorer outcomes.

I'm wondering if what we're recommending here, even if we put in the word require, will end up in five to 10 years in making any headway in addressing those issues.

DR. WILENSKY: I think it's a fair comment. The question is -- I want to know whether we can get to, with the modifications that Floyd just raised, whether people can be comfortable and take a vote on this recommendation. If you want to have a follow-on recommendation that deals with that issue, I don't know if we're ready to do that now. I think it's a fair point, but I'm really trying to push us to vote yea or nay, although I think you made good changes.

MR. SMITH: I guess I'd be comfortable voting for this recommendation on the grounds that it doesn't mean very much, but if it means something it seems to me we ought to be very cautious about saying that with a lot of evidence that some 30 percent of beneficiaries don't get adequate care, that we want to divert a fixed pot of resources to the lowest volume part of that overall inadequate performance.

1 If we wanted to add more resources because we felt
2 the differences really were driven by ruralness rather than,
3 as Carol suggests and I think as all of us had wondered,
4 whether it's driven by low volume. Maybe we ought to say
5 it's never going to make any sense for the PROs to devote
6 their resources to very small, very isolated rural
7 hospitals. Therefore, we need to devote some quality
8 improvement resources to it, and the Secretary should find
9 and provide some.
10 But we shouldn't say it makes sense to divert
11 resources from places where there's a potential big bang for
12 the buck to places where there isn't. That seems goofy.
13 DR. REISCHAUER: There's an equity argument that
14 everybody should have an option of getting --
15 DR. WILENSKY: Of getting reviewed.
16 MR. SMITH: I agree with you, Bob. But then that
17 argues for more resources.
18 DR. NEWHOUSE: That argument is stronger, though,
19 if there's an evidence of problems in the rural areas. But
20 there hasn't been much demonstration of that, is the

problem.

DR. WILENSKY: We don't know that.

DR. NEWHOUSE: But from what we present, this doesn't follow.

MR. SMITH: It doesn't follow that we've got a problem that says we ought to take resources from high density areas and move them to low density areas. Because the evidence is we have the same problem in both areas. And the resources ought to be employed, Bob, it seems to me, efficiently and the equity problem doesn't loom as large.

DR. REISCHAUER: The real issue here is, if you spend a buck how much improvement times number of people can you get in each of these areas? Not sort of the level at which they're at right now. We don't know anything about that topic, which is the marginal impact of another dollar spent in rural versus urban areas.

MR. HACKBARTH: But we're looking at this as though the only quality improvement resources come through the PRO process. To me, part of the issue is that the urban institutions have many more resources as their disposal than

the rural institutions do. They've got much larger administrative structures, different staffing.

If PROs don't do it, there's a chance in the urban areas that somebody else will. In these small rural institutions, if there isn't some government encouragement and support, it probably will not happen.

That's why I think, despite the efficiency argument, there is a legitimate public policy purpose served by saying we don't think the PROs' scope of work should be skewed solely to urban hospitals.

MR. SMITH: But doesn't the relatively modest difference even between the most rural areas and metropolitan areas suggest that whatever is going on that's useful in urban areas or inappropriately or insufficiently useful is also going on even in urban influence code nine?

MR. HACKBARTH: No, I don't think that follows, given what I've experienced and how things happen across the health care system. I think the transfer of best practices, if you will, is actually quite limited. So I wouldn't infer that from the growth similarity in the patterns.

DR. NELSON: I'm not arguing again the use of the word encourage. My earlier comments stand on that.

But I'm more concerned about the way the PROs are currently doing their scope of work. In the HCQIP, Mary, am I not correct that the Health Care Quality Improvement Program is population based? That it's not looking at providers, it's looking at the percentage of patients with atrial fibrillation that receive anticoagulants.

DR. MAZANEC: Right.

DR. NELSON: If a PRO is going to study the immunization rates on the elderly people, they're population studies that -- I may be wrong, but I have the sense that more of the quality improvement activities of PROs now is focused on the population rather than just individual providers.

If we are ignoring that reality in changing the wording that you have here, I think we ought to be aware that we are ignoring that reality.

DR. NEWHOUSE: Isn't that the incentive that drives the PROs toward the urban areas?

DR. WILENSKY: The question is going to be, should it be populations and providers?

DR. NELSON: I'm saying that I believe the word populations is appropriate in here. I don't care if you add the word providers.

It seems to me that this other argument that was going on about urban versus rural is encompassed in draft recommendation two for the point that was made that there are other kinds of quality assurance capabilities in licensing and conditions of participation and accreditation that go beyond just what the PROs are doing.

I think our recommendation with respect to the PROs ought to be consistent with the direction that the PROs have been taking in their quality improvement activities.

DR. LOOP: I agree, and I think we have to have a practical implication here. Are we diverting resources for something that can't really be changed?

If you're looking at volume, volume relates to the number of doctors the socioeconomic status of the patients, the insurance, the distance, and the PRO can't really change

that. So I'm a little worried about this recommendation and how it contributes to regulatory burden, also.

DR. WILENSKY: Let me just respond to that issue. I think to the extent that we later get into questions about whether or not there's some procedures that do better with high volume care, for whatever sets of reasons that is the case, to the extent that you had PRO QI activities focusing on rural populations and rural providers, it might help focus -- if that were the case -- either trying to change the behavior of the providers or trying to change the location of some kinds of procedures in terms of where they were more likely to be provided.

So I think the answer is that while there are some aspects that are not likely to be changed, how you respond to a quality if you find a problem isn't necessarily tied in to not being able to change the setting in which it's located because it may mean be that it would be to try to make it a different differentiation in terms of where certain services are provided than may otherwise occur.

So that will be equally appropriate as an outcome

1 to the extent that it appeared that was the better way to
2 try to respond if there were patterns of care that seemed
3 appropriate by looking at rural populations and providers.
4 DR. WAKEFIELD: Just a couple of comments. I
5 think at least in part, related to the volume issue, the
6 volume is a proxy for other things. Maybe we do or don't
7 have a very good handle on what that proxy reflects. But it
8 might reflect things like a group of staff who work more
9 effectively together, and that can be part of a QI
10 initiative.
11 So yes, volume is important but I'd say we should
12 be stepping back and taking a look at what component parts
13 are associated with that high volume good outcome
14 relationship. And say that QI initiatives can be directed
15 at those component parts potentially.
16 Secondly, I'd say that to the extent that rural
17 hospitals rely on survey and certification, we rely to
18 ensure that beneficiaries have quality care. And they rely
19 more on survey and cert at the state level, as opposed to
20 JCAHO. To what extent does survey and cert processes

1 embrace QI? I think they're primarily QA. I don't think
2 they're QI. So we cannot look to the states in a consistent
3 fashion that I know of to pick up on QI efforts.
4 And the third issue that I guess I'd make is we
5 even say in our document, on page five, yes, we've got some
6 comparable delivery of ambulatory care services, but we've
7 got some differences in clinical outcomes related to some of
8 those services. So some of it is availability or use rates,
9 and some of it is what happens to that patient in terms of
10 patient outcomes? So I guess I'd just reinforce the
11 importance of this particular objective.
12 The last point I will make --
13 DR. WILENSKY: You're arguing in favor of the
14 recommendation.
15 DR. WAKEFIELD: I'm arguing in favor and I'll give
16 one more reason why I'm arguing in favor.
17 Right now I'm working with Don Berwick's IHI group
18 to try and outreach QI to rural hospitals. I can't begin to
19 tell you the difficult circumstances we're dealing with with
20 those rural hospitals across the country just to look at

1 some very basic QI initiatives. It is not easy out there.
2 I think a little bit of help on the front end would not
3 hurt.
4 So yes, I'm arguing for it, with Floyd's language.
5 DR. WILENSKY: I think you're really reiterating
6 Glenn's point, that there are a lot fewer QI activities
7 likely to go on in rural areas. This would basically
8 enforce some set.
9 I'm going to call for a vote on this.
10 DR. NEWHOUSE: Where did we leave the targeting
11 language?
12 DR. WILENSKY: Let me tell you as I understand,
13 what I'm going to ask for is the first vote and we can do a
14 separate vote if we want. To modify draft recommendation
15 one to include rural providers and populations. I think
16 there was an argument to have both words in there.
17 And to delete the phrase in the groups that they
18 consider. So just to include rural providers and
19 populations in carrying out their quality improvement. Am I
20 characterizing your language change?

DR. LOOP: Yes.

DR. WILENSKY: All right. In the first instance we can do a required, although except for Alan I haven't gotten, my sense is that most of you are comfortable with required rather than encourage. I think encourage doesn't really do anything, to be honest. I think either require it or we can have a discussion and don't have a recommendation.

That's a correct characterization, in terms of what to vote on?

All those in favor saying aye.

No?

Not voting?

Now on to the second.

DR. NEWHOUSE: But what about the targeting.

DR. WILENSKY: We can do two things on the targeting. One is that we can have a discussion in the paragraph that follows the recommendation. Or the second is that we can have a second recommendation.

My recommendation is that we have the discussion in the paragraph, but I don't feel strongly. I'd be glad to

listen if people have a recommendation to offer.

DR. NEWHOUSE: I'm kind of responding to the -- I don't think I feel strongly, but I'm responding to the motion that it's kind of uniform across where rural/urban doesn't distinguish much. It seems to me that the right answer to that then is to look for where the problems are, and that rural/urban isn't the right dimension to focus on.

DR. WILENSKY: But presumably that's true at the urban. As it now stands --

DR. NEWHOUSE: Maybe there should be a second recommendation then, for that reason.

DR. ROSS: I'm voting for text, but we'd be happy to explain as much within that, below the first recommendation, that says rural is an all-encompassing term and then just emphasize the diversity underneath.

DR. NEWHOUSE: I guess I still have a problem, which is, I think, David's problem, also. That this recommendation emphasizes rural but the hard evidence in the text doesn't really lead you to this recommendation.

DR. REISCHAUER: How are we defining the problem,

the 2 percent difference between urban and rural or the difference between 70 percent and 100 percent?

DR. NEWHOUSE: That's the issue.

DR. REISCHAUER: I'd be very worried about something like this if I was then told that a third of the resources or 40 percent of the resources were going to be taken up evaluating rural facilities.

MR. SMITH: But, Bob, I think that's what you just voted for. You didn't vote for 30 percent, but --

DR. REISCHAUER: No, I voted for something about considering. It didn't say anything you said.

MR. SMITH: No, we voted to urge the Secretary to require that a fixed pot of resources be split differently to focus more on rural areas.

DR. WILENSKY: In the first place, we're about to vote on something that requires the Secretary --

DR. NEWHOUSE: No, I'm still on one.

DR. WILENSKY: Let me go to Glenn. If there is a specific recommendation that you want to make with regard to a second recommendation, why don't you at least try to

either give a sense to Murray or we can come back tomorrow morning to vote on it.

DR. NEWHOUSE: I want to propose -- this would actually be quite a radical change, but to include those rural and urban providers where there is a pattern of care suggestive of lower quality, as recommendation one. I just think that follows better from the numbers we present in the chapter.

DR. ROWE: And I think it's more consistent with Bob's concern about spending the money where you're going to get the bang for the buck.

DR. WAKEFIELD: Joe, do we know now -- and I haven't looked at this for quite a while, and only superficially. Do we know now what drives PROs, in terms of their selection of different topic areas? So for example, do they choose their focus, diabetes management or CHF, based on numbers in a population affected? Or because there's a trend line that shows poor quality care in that area?

DR. NEWHOUSE: Doesn't HCFA chose that set of

domains in their contract?

DR. WAKEFIELD: Yes, but I think you've got like five or six general areas that they speak to.

MS. NEWPORT: I'd say that, Joe, before we go to that type of explicit language, I would be comfortable saying that I understand the scope of work and the iterations of the scope over time to say that you have to -- to me, just as a gut check for me, is it strikes me as a little different, quite a bit different than the scope and the aim and the way the program has evolved over time.

I could be terribly wrong on that, but I think we should confirm, at least, that we understand what level of change we're driving within the purpose of the organizations.

DR. WILENSKY: I agree. I think if we want to make a statement like that, the most that we ought to do is to consider what that language would look like, have somebody have a discussion with HCFA this afternoon, to make sure we understand the implications of that recommendation. We may have to revisit it because that may be potentially

changing much more than we're understand that we changed.

What we're trying to do at this level is to include as an explicit criteria, of one of what we regard as many, the consideration of rural populations, which because of the wording that is now in there, by their nature are unlikely to make it up into a factor of consideration. Without indicating the weighting or suggesting precisely how to do that. But to have that as one factor in consideration of the selection.

So I don't believe that while it is conceivable you could have the problem that David raised, I don't think anything that we've suggested in any way assures that that will happen. That this is one of the factors under consideration in the selection of populations or providers for review.

But I'm more than willing to consider a reworking or that addition if we're sure we understand how that would affect the scope of work.

DR. NEWHOUSE: Maybe we could find out from HCFA and come back to this.

MR. SMITH: Perhaps we should put it off to later in the afternoon. But Gail, it seems to me the clear meaning of required to include is required to include, not take account of this one factor among many.

DR. WILENSKY: No. Right now, because of the way it is set up, they are likely to be included and I think that it does require them to be included. But there are a number of areas that are required for inclusion, in terms of choosing the populations and the providers for focus. So I think the notion that you had suggested, in terms of the redirection of resources, there will be some redirection of resources. Whether it's substantial redirection of resources I think is not clear from language that we've suggested here.

MR. HACKBARTH: I'm going to repeat myself but I'll go ahead. Practically speaking, this sort of recommendation doesn't provide a whole lot of direction.

DR. WILENSKY: I agree.

MR. HACKBARTH: It is a symbolic statement as much as it is a substantive statement because you could meet the

requirement of this require by putting $1 in and say okay, we included $1 for PRO activity to rural areas.

DR. REISCHAUER: They don't have to do that, they just have to consider.

DR. NEWHOUSE: We took out consider.

DR. WILENSKY: We took out that phrase.

MR. HACKBARTH: But it doesn't say anything about resource levels, nor do I think it should. I don't think our responsibility, our role, is to micromanage that process.

I do think that there is information beyond the similarity and the overall use rates. That is information in the chapter, which is that the administrative resources available for quality activities in rural hospitals are dramatically less than in urban institutions.

Given that fact, I think it is appropriate for public policy to say we are going to take some of the resources that we have available and make sure that they are provided in support of quality in rural hospitals. I do not see any inconsistency in that.

MR. DeBUSK: In fact, aren't we back to the statement I made to you earlier, Mary? What does this really mean?

DR. WILENSKY: This recommendation stands as written and we'll reconsider whether we want to add the phrase that Joe has suggested. I think it is a level of detail that may have more ramifications than we're prepared to make this year. It goes to a much more general statement about quality.

I think, having just thought a bit about it, this is really a chapter on rural. It's appropriate if we believe that QI dollars are not likely to go particularly to rural areas because of the targeting that now exists and that this would change that, the general issue that it looks as though -- to the extent the information is correct -- that seniors might be getting appropriate or best practices 72 or 73 percent of the time, and the difference is not great between urban and rural areas is a focus that we ought to have in our next quality chapter in MedPAC and not really, I think, raised here particularly.

Again, in the discussion I think it is appropriate to make the point that the differences between urban and rural are probably less troublesome than the low, absolute level that we're finding for seniors in general, and that will be taken up again in the future.

I think that, as I've thought about it, is probably a better way to handle the issue that you're raising but let's go try to find out how much impact that would have on the scope of work and we can revisit it in the morning.

MR. HACKBARTH: What if, as an alternative to this, we were to say -- what was your language?

MR. SMITH: Glenn and I were just talking. If we were to pick up on Glenn's point and say that because rural hospitals are much less likely to have quality improvement resources available to them, the Secretary should figure out a way or design a way or develop a way to see that those resources are provided. Rather than the current recommendation which, I agree Gail, it doesn't say 30 percent or $1. But it does suggest that we ought to shift

resources in a way which I think we would all agree, if it happened in any meaningful sense, would be inefficient.

Our point here, and it seems to me is Glenn's, that these resources are less likely, for a whole variety of reasons, size, cost, the incentives built into the PRO contracts, to get to rural hospitals. And that's a problem. Let's fix that problem.

But why would we want to do it by diverting resources inefficiently?

MR. HACKBARTH: To say that, the reason is to supplement the limited resources available, makes the recommendation much more focused, as to the problem it's solving. It's not trying to solve a problem of grossly different appropriateness of care. We don't have the data to support that as a problem.

The problem is that these institutions, with their very lean administrative structures and budgets, if there's no federal support it's probably not going to happen.

DR. NEWHOUSE: I like the general thrust of that, but it seems to me we again there's a big diversity among

rural hospitals. I mean, some of the big rural hospitals could be a major teaching hospital and could be fine. Now maybe that's an item for the text.

DR. WILENSKY: How do you want to change the recommendation of this language specifically?

MR. HACKBARTH: Maybe I could write something out, with Mary's help.

DR. WILENSKY: All right, we'll take this up after lunch, if you want to consider alternative language. Let's go to draft recommendation two. Any concern about reiterating this recommendation from last year, that we have at least one-third of each facility type surveyed annually.

DR. NEWHOUSE: Do we want to put in the recommendation that we're reiterating it?

DR. ROSS: The recommendation will be written that the Congress should.

DR. WILENSKY: And in the paragraph it will indicate this is a reiteration of our recommendation from last year.

MR. HACKBARTH: I support the recommendation. I

guess if I worked in a rural hospital though, I might think of this as a mixed blessing.

DR. WILENSKY: Always.

MR. HACKBARTH: To me that just reinforces my previous point, that these folks have very limited resources. Going through the survey and cert process takes a lot of time and effort, and I don't think it necessarily is a quality improvement activity. I would like to see some resources devoted to the quality improvement, just not the survey and cert process. And the PRO vehicle is the way to do that.

DR. WAKEFIELD: I just have the same concern. Personally, I like reiterating the recommendation. But it absolutely does raise the question about who pays the bill and where do those responsibilities fall to? How much to Congress? How much to the state level? How much to the institutions themselves, et cetera.

I think without a doubt, costs are going to have to be somewhat dramatic because, as we discovered, many of these institutions aren't being reviewed for years on end.

So that, I think, needs to be addressed but it will not come without a cost. And the question is where is that cost coming from?

DR. WILENSKY: Take a vote on reiterating the recommendation?

DR. BRAUN: Do we need to add that phrase, to assure provision of adequate resources? I mean, it's obvious.

DR. WILENSKY: I would think that that ought to be in the text. I think obviously if you're going to do more survey and certification, it is going to have an increased cost.

All those in favor, raise your hands?

All those opposed?

All those not voting?

Okay, Glenn, if you can give some rewording, we'll raise this immediately when we reconvene. We'll reconvene at 1:30.

[Whereupon, at 12:49 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:52 p.m.]

DR. WILENSKY: Let's reconvene. I want to begin by turning it over to Glenn to share with us the results of the caucusing done with David and I think Bob Reischauer was involved with this, and a little advice from HCFA to make sure we had an understanding about the current scope of work by the PROs. Glenn?

MR. HACKBARTH: I failed, Gail, to come up with language that mustered more support, more enthusiastic support, than what we had already voted on. I think we probably have gone past the point of diminishing returns in the discussion.

So with that in mind, I recommend that we just stand by the vote that we've already taken and move on.

DR. WILENSKY: I think maybe what we can try to do is raise in discussions, in the discussion that follows the recommendation, some of the issues that we talked about. If it wasn't clear, you can make sure, sharing with Murray, the sense of what we want to make sure is included in that paragraph following the recommendation.

Let me turn this over to Jack.

MR. ASHBY: A couple of introductory remarks here. First of all, you'll be happy to know that we really tried to limit our presentation here today. It's still not exactly what one would call short, but we really did work at limiting it down.

We are only going to present the draft recommendations --

DR. NEWHOUSE: We need a quality assurance methods to shorten a presentation.

MR. ASHBY: Better than ever, that's right. We hope.

We're only going to present the draft recommendations themselves, or options for recommendations if that's as far as our thinking has gone. And in a few cases, analyses that are new since our last meeting. Most of those new analyses are estimates of the impact of these various policy options. I'm sure you all noticed that they were not in your mailing materials. They just came off the computer about last night, as a matter of fact.

We have a couple of other scattered things that don't exactly fit into the flow of the presentation, but are new and we thought that you'd find them interesting and so we kind of inserted them briefly into the presentation.

If you look at the first overhead, this is an outline of where we're going here. We'll start out by returning to the financial analysis that Jesse presented last time. Here we have only one chart to present, so that's a one minute session. Then we're going to work our way through the five areas where we do have potential recommendations.

Now the chapter has one additional session, and that's the treatment of length of stay. But I just wanted to remind ourselves that we decided last time that we're going to hold that until the next cycle. So we left it off the agenda today all together.

Lastly is an entirely separate discussion of payment issues that have to do with rural site facilities, that Sally will be doing.

If you look at the next overhead, I wanted to

explain our impact analysis briefly.

DR. ROWE: Before you get started, Jack, can I ask the chairs how we're going to do this? Are we going to do this sort of when we get to the recommendation -- could we have a lot of different pieces, as Jack just outlined.

MR. ASHBY: There's five different pieces. Do we want to go through them all or do we want to deal with them one by one.

DR. ROWE: That's my question.

DR. WILENSKY: Why don't we go through all of the information and then we'll take up the recommendations at the end one by one.

MR. ASHBY: All right.

I wanted to take a look at how we went about doing this impact analysis. This is the impact of the various option on Medicare inpatient margins. It compares a baseline margin with the margin that would result from the policy being implemented, costs held constant.

The baseline for this is the '99 actual margin adjusted for the change in disproportionate share payment

policy that was enacted through BIPA and has already gone into effect. That change, if we can review back to March, would increase rural hospital payments by 1.7 percentage points.

It was suggested at the last meeting that we examine the impact of the options on hospitals with margins below zero. We did take up that suggestion. So we defined a low margin group and a high margin group, the low defined as below zero and the high as above 12. You'll see here how those groups fall out. A much larger proportion of the rural hospitals are low margin than the inpatient, so we need to keep that in mind as we look at the impact on these groups.

The last thing I just wanted to say is that the primary purpose of our session today, of course, is to finalize our recommendations. But we also have a fairly lengthy draft chapter and this is an opportunity to make comments on that draft. If you have fairly minor or editorial comments, feel free to just give them to us so we can keep things moving, but there is the opportunity to

raise significant issues with drafting that need to be discussed.

So unless there's any questions, we'll get on with the first session, which is financial.

MR. KERNS: The first thing we want to do is update you with the rural hospital financial performance by degree of ruralness. While most of the analyses in this presentation will discuss the classic rural hospital groups, we wanted to bring you up to speed on these new findings, especially after Julian's presentation this morning.

This table shows three things. First, the Medicare inpatient margin is skewed in favor of the most urban and the most rural hospitals, which have the highest inpatient margins and the smallest proportions of negative margins. That the most rural hospitals had a margin exceeding 8 percent suggests that the existing special payment policies that seek to target isolated hospitals have indeed had a positive effect, at least on average, for these hospitals.

Second, the opposite story holds for the hospital

total margin. Although rural hospitals generally have higher total margins than urban hospitals, the most isolated rural hospitals are an important exception. They had the lowest margin at negative 0.4 percent.

DR. ROWE: Could you clarify whether total margin means total margin?

MR. KERNS: Yes, total margin, not Medicare. All payer.

DR. ROWE: Or total Medicare margin?

MR. KERNS: No, all payer.

DR. ROWE: And inpatient margins means --

MR. KERNS: Medicare inpatient.

DR. ROWE: You're mixing terms a little bit then.

MR. KERNS: There's only so much room on the slide.

DR. ROWE: So inpatient margin is only for Medicare, but total margin is for all payers?

MR. KERNS: You're right. That was originally in the title and to save space I took that out.

DR. ROWE: And total margin is all payer?

MR. KERNS: Yes, sir.

DR. ROWE: And inpatient margin is Medicare only?

MR. KERNS: Yes, but this gives you at least some idea of how they're performing under Medicare and then overall.

DR. WILENSKY: You could have done a total Medicare margin?

MR. KERNS: Yes. We have that, too.

DR. WAKEFIELD: You don't have outpatient care then?

MR. KERNS: No, but we could run that. I think the outpatient is going to look the same for all the groups, within a negative 15 and negative 20 it's being skewed.

DR. WAKEFIELD: [inaudible].

MR. KERNS: Yes, and I can do that. I could do that, there was only so much room.

To go with the story about the total margin, why that's interesting is that rural hospitals generally do have higher total margins. The fact that it doesn't work for the most isolated rural hospitals is a fairly important point.

The third point is that the inverse relationship of Medicare inpatient margins and hospital total margin suggests that although efforts to increase Medicare payments to hospitals in those areas appear to have had a favorable impact, they may not be enough to make up for other market pressures.

Large urban hospitals face the most financial pressure from uncompensated care and managed care while the most isolated rural hospitals may also face pressure from uncompensated care as well as from very low volume and difficulty in attracting skilled workers. These pressures underscore that the problems of these hospitals go well beyond Medicare.

MR. ASHBY: Okay, on to our first policy area, which is disproportionate share.

MR. DeBUSK: One thing before that, on the urban percent with negative total margin, is that from operations or is that from all sources of income?

MR. KERNS: All sources of income, including non-patient revenue.

MR. DeBUSK: See now there we get really skewed right there.

MR. KERNS: You're right. That does include non-patient revenue and everything else.

MR. DeBUSK: We need to be looking at operations, not income from other areas.

DR. WILENSKY: First, I think there's a question of whether we have the data for that. But the second is I think there's also a policy question, depending on what we want to look at, as to whether or not we want to look at total margins that show the financial well being at a moment in time of a hospital. We have total Medicare margin, which we're seeing. Or we have total margins.

Those are all valid numbers, but I think that there's nothing that is inappropriate about having a total margin, as long as you distinguish that's what you're looking at.

MR. DeBUSK: I understand what you're saying. But looking at these, when these are put together, to see what this would look like after the last three or four months of

1 the stock market, it would be a whole different look. But
2 I've said enough, that's just an outlier.
3 DR. ROWE: The inpatient Medicare margin, that's a
4 core Medicare payment? Or does that include DSH and GME and
5 all the rest of them?
6 MR. KERNS: DSH, GME, IME, they're all netted in
7 there.
8 DR. ROWE: So we're not really comparing apples to
9 apples here. Those are special payments.
10 MR. KERNS: On the urban side, for sure.
11 DR. ROWE: Totalling rural, also. That's why the
12 8.4 is there.
13 MR. KERNS: That's why I said the --
14 DR. ROWE: That's special payments.
15 MR. KERNS: The efforts to reach those hospitals
16 appear to have made a real difference.
17 DR. WAKEFIELD: What did you say, Jesse?
18 MR. KERNS: That the totally rural inpatient
19 margin does reflect the efforts to send special payments to
20 those hospitals, such as sole community and critical access.

Well no, critical access wouldn't be because it's not in the database.

DR. WAKEFIELD: I'd just ask you again if some point in time we could have the outpatient data on this, too, for rural hospitals.

MR. KERNS: Yes, absolutely.

DR. WAKEFIELD: To me, that's at least as important as inpatient margin. Total margin, that Medicare margin --

DR. ROWE: We have that in the chapter.

MR. ASHBY: We didn't bring it up today, Mary because it was just a matter of focusing where the action is. The outpatient doesn't have anywhere near the variation that the inpatient does.

MR. KERNS: Jack is definitely right.

DR. WILENSKY: Again, this chapter is inpatient. We have a chapter that we will be dealing with tomorrow that is outpatient.

DR. WAKEFIELD: Right. It's the total margin all payers that led me to ask for that.

MR. KERNS: I could get those numbers for you, Mary. That's going to be part of our output. Any other questions?

MR. ASHBY: On to disproportionate share. If we can look at this first overhead, this is the draft recommendation. It's the same one that we had up at the March meeting. But to review the history just very briefly here, we have a MedPAC proposal on the table, of course, that would equalize payment rates between urban and rural hospitals in addition to bringing incomes in care into the low income shares used to distribute monies.

Congress partially implemented that recommendation. It at least equalized the eligibility requirements for DSH but capped the DSH add-on at 5.25 percent for rural hospitals, whereas there is no cap on the urban side.

This recommendation would essentially represent a second step in reforming DSH. Not the full thing, but a second step. The BIPA change eliminated about one-third of the discrepancy between urban and rural. This change would

eliminate about two-thirds of the discrepancy between the two groups.

Looking at the impact table on the next slide, I wanted to highlight just two things here. First, the proposal would raise payments in rural hospitals by 1.4 percent, and there would actually be an increase of similar proportions for urban hospitals with less than 100 beds, but there are so few of them that, as you see, the urban impact actually rounds to zero.

Secondly, I wanted to point out that the largest increases would go to the last two groups. These are the rural hospitals that don't currently benefit from any of the special payment provisions that are on the books. We think this is a good outcome, really. It's an equalizing, leveling the playing field kind of an outcome.

But that's a lead-in to the next table, where we see sort of a different outcome. Unfortunately, we see here that at the individual hospital level, the targeting is not the best. The increase in payments is actually a bit greater for high margin rural hospitals than low margin

rural hospitals.

That speaks to the problem of continuing to base disproportionate share on low income shares that don't reflect uncompensated care and, in essence, speaks to why it's important that we stop short of eliminating the cap all together.

We did do a simulation similar to this two years ago of our full proposal that does bring in uncompensated care. And there we found a very different outcome. It did indeed raise payments for the low quartile by margins considerably more than the high quartile. So this sort of emphasizes that it's a useful step but it does not take it us all the way to where we need to be.

So that's the picture on the DSH recommendation. I guess we would probably want to take questions at this point, or should we just continue straight on?

DR. WILENSKY: I think we ought to continue, and then before we get to the discussion on the psych hospitals, go back and take each of these recommendations up, in terms of either modifying or voting.

MR. ASHBY: All right, then the next is low volume adjustment with Craig.

MR. LISK: I'm going to talk about the small scale operation section of the report and the potential recommendations you can make. This first table here shows the overall financial performance, both Medicare inpatient PPS and total margins for hospitals if there is total discharge volumes.

As you can see, hospitals with less than 200 discharges and those with under 500 discharges both had negative margins on the inpatient side and actually also for total margins with essentially, more than half of these hospitals having negative inpatient PPS margins and actually also on the total margin side of things. So their financial performance is overall worse than higher volume hospitals.

DR. ROWE: This is all payers total.

MR. LISK: The total margin is all payers; correct. So those numbers are actually pretty large, in terms of the proportion of hospitals that have negative margins. Again, these are low volume hospitals and this is

1 including their total overall business, as well. So it's
2 just not the inpatient care.
3 If you recall previously, we did discuss that
4 inpatient care is not necessarily a large share of these
5 providers' business.
6 So we have a recommendation and we presented the
7 information to you before on what a low volume adjustment,
8 in terms of what the relationship between low volume and
9 patient care costs are. We have a potential recommendation,
10 it is that the Congress should develop a graduated
11 adjustment to the rates used in the inpatient prospective
12 payment system for hospitals with low overall discharge
13 volumes.
14 DR. ROWE: Low would be less than 500?
15 MR. LISK: Low would be less than 500. What we
16 did for a simulation is something that's similar to the
17 overall relationship. It was something that's relatively
18 simple.
19 DR. ROWE: You have that curve.
20 MR. LISK: Essentially we did though actually a

1 straight line, from starting at a 25 percent adjustment for
2 the very lowest going to zero once a hospital reaches 500.
3 So we did it just for simplicity, there's different
4 alternatives that could be done. But that's what we ended
5 up modeling.
6 So given what we modeled, the next slide shows the
7 potential --
8 DR. WILENSKY: I want to raise an issue. I assume
9 it will come up on a number of times. It's going back to
10 this inpatient Medicare in total margin. I'm finding this -
11 - it's not obvious when you pick up the table what you're
12 looking at. You've got to label Medicare inpatient and
13 total margin AP, all payer.
14 MR. ASHBY: We will make sure that is clear in the
15 report. We can at least say that every table from here on
16 out will be Medicare inpatient margin.
17 DR. WILENSKY: Just because when normally you'd
18 pick it up, you'd think you'd be looking at Medicare
19 inpatient, Medicare total, or total inpatient or total
20 total, and it was not at all obvious that you do Medicare

inpatient and then total all payer.

DR. ROWE: Your glee, Jack, with the fact that all the tables will be Medicare inpatient reminds me of the fact that we tried to kill the concept of Medicare inpatient a couple of years ago [inaudible] because we thought it was misleading and we should use at least the entire Medicare rather than just Medicare inpatient margins. So maybe we could, when we get to the chapter, make sure we include at least a total Medicare margin.

It seems to me one of the problems we have is the unit of analysis. Maybe if we get the Medicare inpatient margin right for all hospitals, somebody says well what about the inpatient cardiac margin or inpatient ESRD margin? We're always going to find something that's unequal.

MR. ASHBY: On the other hand, for the purposes of viewing the impact, we sort of thought the inpatient margin was the best way to see the impact, because after all this is an inpatient payment system. The broader is important perspective, but this is what we first and foremost want to look at, is what is the impact on the payment system we're

trying to design there?

DR. WAKEFIELD: Could I comment on that? I think I kept using the terminology of patient and I want to make sure Jesse doesn't go off in a direction that I wouldn't have intended him. What Jack just said, I think it got me back on the right track.

What I was interested in was what I think you termed most of Medicare, the MOM margin, about a year ago. That's what I was asking for. That's what we were asking for, I think, at the commission starting about a year ago, which would be most to have reflected here.

Take out my request for outpatient, I was interested in that broader category. My apologies.

DR. NEWHOUSE: Jack, I'm not sure I agree with what you just said in response to Jack, that what we should be interested in is the Medicare inpatient margin, or total Medicare or total total.

I would agree with you if it were something that affected the weights or relative prices for inpatient care. This is basically an add-on that goes to the hospital to use

as it seems fit, in a sense. For that, it seems to me --

MR. ASHBY: For disproportionate share, particularly.

DR. NEWHOUSE: DSH is what I mean specifically. For that purpose, it seems to me, a total, one or the other of the totals is what's relevant. Probably the total --

MR. ASHBY: Yes, you're absolutely right, DSH is different in that sense.

MR. LISK: Moving on. This is the recommendation. What I want to now go over is generally the impacts of implementing low volume adjustment. I have three sets of margin tables. Again, as Jack said, these are inpatient margins and we have what is the baseline margin and what is the margin after the policy change.

The net effect, though, is of a low volume adjustment as we modeled it is the amount of payments that would go for this. And this is not budget neutral, so the 0.0 actually rounds down to zero. The amount of money put into the system for this would be roughly $22 million to fund the low volume adjustment. It would increase payments

to roughly 10 percent of the hospitals, in terms of doing that, without any access criteria.

So the amount of money that we're talking about is relatively small, so when you look overall, in terms of increases in change of payments for aggregate rural hospitals, we're only seeing a .2 percent change, for instance. But you see a slightly larger change for Medicare dependent and other rurals that are less than 50 beds.

About a quarter of low volume hospitals that are receiving hospital specific rates under the sole community hospital program or Medicare dependent hospital program, would start receiving PPS rates under the low volume adjustment. So the new PPS rate would be higher than the hospital specific rate for those providers.

Moving to the next slide, though, this is where we show what more of the impact is on the inpatient margin for low volume providers. So we only see the effects here of the hospitals with less than 200 beds and 200 to 500 beds. As you can see, the inpatient margin goes down from 16.4 down to 5.7 percent for those with less than 200 beds.

There's 11.2 percent --

DR. ROWE: Discharges, not beds.

MR. LISK: 200 discharges. Less than 200 discharges, thank you. As you can see, there's 11.2 percent change for that group as a whole and 4.8 percent, about 5 percent, for those between 200 and 500. That does dramatically improve their margins, as you can see.

DR. ROWE: That's the same, $22 million?

MR. LISK: That's still the same, just $22 million; correct.

DR. ROWE: So it's really a small number of hospitals.

MR. LISK: It's a small number of hospitals. It is roughly 10 percent of hospitals would see an increase in their payment here, though. So it's a small number, but it's a relatively big impact. This has been mentioned before, in terms of what's the improvement in terms of how many would be brought above zero in terms of negative margins.

Still, the majority of those hospitals with under

1 200 discharges would still have negative margins. Of those
2 with the 200 to 500 discharges, where 50 percent had
3 negative margins, it would be brought up to only 37 percent
4 having negative inpatient margins.
5 DR. REISCHAUER: Are you making the adjustment you
6 talked about, where the two low volume hospitals right next
7 to each other, counting them as one?
8 MR. LISK: No, we're not. This is not providing
9 any access criteria involved. This is just doing the
10 adjustment, whether you're low volume. Now I'm going to
11 report on something about that in just a moment here. Maybe
12 that's a good transition for this. It's not a slide.
13 MR. SMITH: One question. I just want to make
14 sure I understand what we're looking at here. The baseline
15 Medicare inpatient margin on the slide that you just showed
16 for less than 200 discharges is 16.4.
17 MR. LISK: That's different from the margin on the
18 previous chart. That is because one is what is the '99
19 margin and the other is we're simulating 2001 payment policy
20 with the DSH changes and other changes that were made as

part of BIPA. So that had a net effect of increase the margins slightly.

MR. ASHBY: It just adds in payments that they've already received.

DR. ROWE: Does BIPA have an effect here? Is this pre-BIPA, post-BIPA?

MR. LISK: This is post-BIPA but in reality the hospitals are pre-BIPA in terms of how they're actually operating, in terms of the...

DR. REISCHAUER: There's no BIPA behavioral response.

MR. LISK: There's no BIPA behavioral response, correct.

DR. NEWHOUSE: We don't know.

MR. DeBUSK: If we're going to take -- that $22 million change affects your less than 200 and 200 to 500, why would you not pool the lowest one there, less than 200 discharges, up to at least where it was a break even?

MR. LISK: That would be an issue in actually developing what you had. That's one of the options between

bringing a cost-based system -- you know, paying based on cost versus providing an adjustment like this, as well.

DR. ROWE: Don't get trapped here, Pete. This is just the inpatient. The smaller the hospital is, the greater proportion of the hospital's activity is non-inpatient. And until they show you what the total Medicare margin is for those hospitals, you don't...

DR. NEWHOUSE: Also it may be across the street from another hospital.

MR. ASHBY: Rest assured though that when we do go to total Medicare, it will still be negative.

MR. LISK: I don't have a slide on this but in terms of talking about across the street from other hospitals, we recently got road mile distance measures in, in terms of saying how many of these hospitals are X miles away from another hospital. What we reported in your paper were air mile distances, and now we have road mile distances. Unfortunately, I don't have a slide on this. But I can give you the basics on this.

For the hospitals that are less than 15 miles

apart, 14 percent of the low volume hospitals are less than 15 miles from other hospitals. So 86 percent are more than 15 miles, so are a fair distance from another hospital. In fact, 51 percent are more than 25 miles distant from another hospital.

So that gives you an idea that a large portion of these hospitals are not close, using a 15 mile standard for instance, to another hospital. So I think that's important to bring up.

The next slide shows low volume impact on the low margin hospitals and the higher margin hospitals. Here we see small changes for that group overall. But again, since they make up such a small portion of all these hospitals, you're not going to see big changes here.

DR. ROWE: Jack said that, rest assured it would still be negative and I want to see, if we brought -- what did you mean by it would still be negative.

MR. ASHBY: In the end, you see that -- actually it was on the previous chart -- that in the less than 200 discharge, even with the adjustment, they still have a

negative inpatient margin. My comment was if you brought in the other services, so you had total Medicare rather than just inpatient, it would definitely still be a negative. The other services are not going to raise their margins.

DR. ROWE: That's my question.

MR. ASHBY: That we know.

MR. LISK: The other aspect with hospitals with negative margins, for those that we classified as totally rural hospitals in the previous slides, the number with negative margins would drop from 35.5 percent to 25.8 percent. So we would reduce that proportion quite substantially, in terms of that group that has negative margins.

DR. WILENSKY: I'd like to remind the commissioners that apropos our earlier discussions, what we have talked about are strategies that Medicare can adopt that are reasonable Medicare changes that would also have a beneficial effect on rural hospitals.

So to the extent that we have seen presented information that suggests that low volume hospitals have

costs that are different from, scale effects that are different from the other hospital structure, there is a good justification for making a low volume adjustment.

But it would be at least very contrary to the notion of saying shouldn't we just wipe out any negative margins, whether we're talking about total margins or inpatient margins, again to try to make the distinction that we're trying to fine tune the Medicare payment strategies in ways that better reflect costs, and that we can use in good conscience to justify under Medicare changes. And to the extent that we think there may remain policy issues that are appropriate for the Congress to think about, that would assist rural areas that go beyond Medicare, we ought to regard them as separate.

We have stated that, but I think we're sliding back into this problem, when we talked about why we didn't get rid of all the negative margins.

MR. LISK: So the next slide, you may want to consider having a recommendation on an access requirement,

and that's what this slide provides that recommendation for, in terms of the Congress should only apply a low volume adjustment to hospitals that are more than a specified number of miles from another facility providing inpatient care.

We simulated the less than 15 mile criteria and that would reduce the total payments going to low volume hospitals to about $17 million. In terms of the proportion of hospitals affected, it would reduce the number by 14 percent basically.

DR. WILENSKY: We'll come back to discuss this. It seems like a lot of trouble for 14 percent of the hospitals.

MR. LISK: Thank you.

MR. ASHBY: The next is wage index related issues with Julian.

MR. PETTENGILL: At the last meeting we started out by discussing why an accurate input price adjustment is necessary. And we also identified the particular problems with the wage index that need attention, which include

occupational mix differences, labor market size and boundary problems, the age of the wage index data, and the issue of whether the labor share may or may not be too high.

What I'd like to do this time is respond to some questions that were raised at the last meeting, by Jack in particular, and highlight the policy options under discussion and their consequences. And finally, review the draft recommendations you saw last time.

I'd like to start with these bar charts, just for fun. A lot of people had the impression that wage index -- wage rates are high in urban areas and low in rural areas, and that's certainly true. But there are also some rural labor markets where the wage index is high and there are many urban labor markets where the wage index is low. There's a lot of overlap here.

DR. ROWE: Which is correct, the one you're showing or the one that's in our packets?

MR. PETTENGILL: There's two. One of them shows the distribution of the wage index, urban and rural wage index values by labor market area. That is, it shows you

how many of the labor market areas are distributed at what level.

That's rural labor markets and urban labor markets.

DR. ROSS: They got reversed in your packet.

DR. ROWE: So this one is the second one in our packet?

MR. PETTENGILL: Right, and that's hospitals.

So that's the story. There are, however, more hospitals, more rural hospitals, toward the lower end than there are rural labor markets to the low end. And the urban hospitals, correspondingly, are more concentrated at the upper end.

Let's talk about options for dealing with occupational mix. This is mainly where the action is, I think, at the moment. People have identified a number of different options. One, in the longer run, use occupational specific wage data. That's something that HCFA is working on, and presumably will be available three or four years down the road.

In the short run, people have talked about establishing a wage index floor, for example at .9, .92, .925. Compress the wage index by raising it to a power of less than one. That is, drag it in from both ends. Complete the phase out of the existing wages for teaching physicians, residents and CRNAs. Those are the three options, as far as I know, that are on the table.

The next overhead illustrates the effects of a floor and compression. You saw a version of this last time. This one differs only because I added a wage index value of above one to remind people that when you compress the wage index it comes up at the low end but it comes down at the upper end, as well.

The next table shows the proportion of labor markets. This is a question that Jack raised about what fraction of labor markets, hospitals and discharges would be affected by the floor? Well, if the floor were set at .9, 38 percent of the urban labor markets and 72 percent of the rural labor markets would have their wage index raised. Similarly, 23 percent of the urban hospitals and 87 percent

of the rural hospitals would have the wage index raised. Those rural hospitals account for 89 percent of all rural discharges.

So there was a notion, I think, last time that maybe this would be something that would only affect small hospitals. That doesn't appear to be the case.

DR. ROWE: Were you surprised by this?

MR. PETTENGILL: No. No, I'm not. If you're affecting all of those rural labor markets, they're all over the country. They're state-wide rural areas that have got everything in them.

DR. ROWE: The reason I ask is I wanted to make certain that if we were making a change in order to meet a policy goal, that it actually reached the institutions you're trying to reach rather than some [inaudible].

MR. PETTENGILL: Of course, it depends on what your policy goal is, but I think that the policy goal of the wage index, in general, is to make payment rates accurately reflect market conditions.

DR. ROWE: I agree with you that it depends on

1 what your policy goal is. We can interpret the introduction
2 to the chapter as the policy goal is to equalize the
3 Medicare inpatient margins. That would be one policy. It
4 sort of depends on what your policy goal is.
5 DR. WILENSKY: Again, I think it's why we need to
6 go back to where we started this morning, that what we are
7 trying to do is to look at access to care, quality of care,
8 for seniors in rural areas. And particularly to the extent
9 that we can refine payment rates or quality assurance
10 strategies that would improve either the quality or improve
11 the access for seniors that we ought to make such
12 recommendations as are appropriate.
13 To the extent that we think there are legitimate
14 policy issues that are being raised in rural areas that go
15 beyond Medicare, that we ought to reference other strategies
16 for their resolution beyond Medicare. I think that's one of
17 the issues that we keep tripping on.
18 DR. REISCHAUER: On the hospitals, 87 percent
19 being affected, have you taken out the ones that have gotten
20 reclassified? And if not, what fraction of all rural

hospitals? Are we at 100 percent here?

MR. PETTENGILL: No, this is a really -- even thinking about the floor puts you in a very peculiar place when you start talking about reclassification because as soon as you put the floor in, you're going to have a lot of hospitals that reclassify. And now they have no reason to reclassify, so presumably they would not longer reclassify.

We did not make any attempt to model that. Those are decisions that hospitals -- it's an application process. A hospital gets to choose what they're going to do.

If we had more time to play with it, we could take that into account. I'm sure that some fraction of the hospitals, perhaps a substantial fraction of the hospitals here, affected by the floor are hospitals that reclassified. There are 490 reclassifications in 2001 and the vast bulk of them are rural hospitals.

MR. HACKBARTH: We're looking at imposing a floor or compression as options because the true fixes are all out in the future, of fixing the occupational mix problem or the labor market definition?

MR. PETTENGILL: Right.

MR. HACKBARTH: That's the context for looking at this? There isn't any particular reason for imposing a floor based on the way the index is calculated, that we need a floor?

MR. PETTENGILL: That's right. Actually I think that brings up two interesting points. One, is that if the problem you're trying to fix is occupational mix, what will happen is if you used occupational specific data, the values for some labor market areas that have major teaching hospitals with lots of teaching positions and residents and high paid staff of all kinds would come down.

And because the wage index is calculated, any change in it is budget neutral. The wage index values for the remaining markets would come up, but not very much for the most part. So if you're going to take the wage index value for a market from .75 up to .9, that's a much bigger change than you would ever get from occupational mix differences.

The second point is that if you're going to fix

the labor market areas, which by the way I don't think is going to happen any time soon because it's a really difficult problem, then if you -- what fixing the labor market areas means is taking these big areas and cutting them down so that they really represent hospitals that are competing for the same pool of labor.

If you did that, what you would do is isolate a lot of the hospitals that are located out a way from the cities, which are not now isolated. Those hospitals are counted in the same labor market area, state-wide rural area, and the current wage index shelters them. It's higher than the wage rates they're actually paying.

If you narrow the labor market area definitions, what would happen is their wage indexes would go down. And in many cases, they would go down substantially.

So what problem are we trying to fix here? Does the floor take you in the right direction? It doesn't take you in the right direction for the more isolated rural hospitals. It takes you in the wrong direction.

For the hospitals that are near urban areas and

have higher wage rates, perhaps the floor takes them in the right direction. I don't know. Does it take them the right distance in the right direction? I don't know. You'd have to know what the new labor market areas would look like in order to answer the question really.

But I do know for the more isolated hospitals you're going the wrong way.

DR. WILENSKY: I think the more relevant answer is it was raised as a policy option because it's been put on the table. It's hard to imagine on a pure policy ground, even with the difficulties, that a floor would be the response, that the floor would be the policy response. I think that we strongly agree that we need to improve the definition of an appropriate labor market and we need to include the occupational mix. We support that. But it would be hard to imagine the policy justification for using a floor on the wage index. We'd have some serious questions about whether we're overshooting the appropriate level, the likelihood of getting it back from the appropriate level once you set a floor strikes me as about somewhere around

zero.

DR. ROWE: How do we reconcile that, Gail, with the fact that we have recommended or the Medicare program or somebody has recommended floors in the Medicare+Choice program for counties and things like that.

DR. NEWHOUSE: We didn't recommend that.

DR. WILENSKY: I believe that we not only didn't recommend it, but we're now on record in our recommendations and discussions as saying that we believe that the direction that we've gone in moves away from budget neutrality on the part of government between traditional Medicare and Medicare+Choice.

So while obviously Congress will make the decisions that Congress believes is appropriate, I think that the Medicare Payment Advisory Commission ought to make the recommendations that it believes are consistent with the structure that we set up.

DR. ROWE: I guess what we should do then, if there's a statement about the purest or the theoretical perspective on the floors, I guess if Congress is going to

1 be reading this, or whatever, I guess there should be some
2 indication to say that notwithstanding MedPAC's position
3 with respect to this, there are some elements in the
4 Medicare program that use this kind of a thing. Do you know
5 what I mean?
6 What is HCFA's response to your -- I'm not an
7 economist. What does HCFA say in response to your or our
8 position about floor as a bad idea in Medicare+Choice? Are
9 they against it, too, and just Congress did it?
10 DR. WILENSKY: I suspect it would depend on who
11 you asked. I think that the fact that Bob Reischauer and I,
12 who are sometimes in different places -- although not all
13 that often -- in terms of recommendations, we're very
14 consistent on the problems that you've raised in
15 Medicare+Choice by trying to respond to geographic
16 disparities by minimizing or lowering geographic disparities
17 in introducing larger disparities between a single market.
18 I thought that both the chapter and the executive
19 summary very appropriately indicated the problems. My
20 presumption, unless the commissioners choose to move away

1 from it, is that a wage index floor is not consistent with
2 where we've been and where we will be in the future. This
3 is a policy decision that Congress may choose to make for
4 redistribution purposes to the rural hospitals, and that's
5 their choice.
6 But on grounds of including Medicare payments,
7 it's hard to get there.
8 MR. HACKBARTH: I'd feel comfortable with that
9 basic reason. I'm also troubled by the possibility that if
10 we put in a floor and then we get the data to do
11 occupational mix, it goes in the opposite direction and
12 we've just really made a hash of the whole situation.
13 DR. NEWHOUSE: That same logic could be applied to
14 compression. It may overcorrect.
15 DR. WILENSKY: Yes, I think all the comments that
16 we made with regard to the floor are equally appropriate for
17 compression.
18 MR. PETTENGILL: The next chart shows the extent
19 to which the floor would affect hospitals with low margins,
20 low PPS inpatient margins. You can see that it would affect

a fairly substantial proportion of hospitals with low margins, 24 percent for urban low margin hospitals and 78 percent for rural. And that the changes in the wage index and in PPS payments would be pretty substantial on average.

That's perhaps not surprising, but what's also interesting is if you look at the next chart you see the fraction of high margin hospitals that would be affected by the floor. And those numbers are pretty large, too, 18 percent for urban and 84 percent of the high margin hospitals for rural would be affected. And the changes in the wage index would be even bigger.

The next one shows the -- we modeled this without budget neutrality because I presume that the proposal on the table in certain places is to use new money. So we modeled it without budget neutrality at a level of .9, just because we're stubborn. These are the results.

You can see that it would raise payments 3 percent for rural hospitals on average. When you get down into some of the smaller rural hospitals, the percentage changes would be larger, 5 percent, 5.1 percent. And of course, it would

raise their margins substantially.

The next chart shows the same kind of information for low margin and high margin hospitals. And there's nothing surprising about any of this.

MS. ROSENBLATT: What's the dollars?

MR. PETTENGILL: I don't know. I honestly don't know. Murray told me, we don't make cost estimates.

[Laughter.]

DR. WILENSKY: The fact that this is not budget neutral, I think we absolutely need to include some idea of how much money we're talking about in this non-neutral world.

MR. PETTENGILL: Okay.

DR. REISCHAUER: The other one was $22 million.

MR. PETTENGILL: This is substantially --

DR. WILENSKY: Because you can't talk about doing this without saying how many billions are we talking about here.

DR. ROWE: This is not budget neutral.

DR. WILENSKY: This is new money.

MR. PETTENGILL: Jack says about $500 million.

Compressing the wage index has many of the same difficulties. It's just that in addition to that it would reduce wage index values inappropriately at the upper end and there's little reason to believe that compression would, in the end, end up improving the accuracy of the wage index or the accuracy of Medicare's payments under PPS. The impact table for compression is on the screen.

This one, the overall impact here is very small because you're bringing down wage indexes at the high end and raising them at the low end to some degree. And in this case, we estimated it with budget neutrality because a change in the wage index of this nature would, unless Congress changed the law, would be budget neutral. But it has exactly the predictable effects. It would reduce wage indexes in payments for urban hospitals and raise them for rural hospitals. Although it depends a lot on which urban hospitals you're talking about, because some of them are in low wage areas.

For low and high margin hospitals, that's on the

next overhead, you would raise payments for both low margin urban and rural hospitals and lower them for high margin hospitals on average. But of course, the effects here are really pretty individual. You're going to get very different effects. For some low margin hospitals they're going to go up and others they will go down, actually, because low and high margins are not associated with the wage index.

The last option is completely --

DR. REISCHAUER: I just have a question about these. These margin percentages that you give are weighted by size? Or are they hospital averaged?

MR. PETTENGILL: They're dollar weighted.

DR. REISCHAUER: They're dollar weighted?

MR. PETTENGILL: Yes. They're aggregate margins.

DR. REISCHAUER: The cost estimate for the other one was $308 million.

MR. ASHBY: Could I just interject for a moment? I was mixing up my large options here. This is not the $500 million one, this is the $700 million one.

DR. REISCHAUER: No, it can't be. If the numbers are right, the .2 percentage point change in rural margin is $22 million, then --

MR. ASHBY: Yes, but there's a big rounding effect there, on the .2 percent.

DR. REISCHAUER: You're doubling what I'm saying. That's big, big rounding.

MR. PETTENGILL: We will get you hard numbers.

DR. REISCHAUER: It's big.

MR. PETTENGILL: It's big, yes.

The last option was completing the phase out of wages and hours for non-PPS activities, teaching physicians, residents, and CRNAs. The impact table for that, there's no chance of going too far with this one. Occupational mix adjustment would do the same thing, only a little bit more.

This again is budget neutral. I don't know where we got minus 0.0. We would be reducing payments slightly, .1 percent for urban hospitals and raising them .3 percent for rural hospitals with slightly bigger effects for some categories of rural hospitals and with corresponding changes

in the margins. For low margin hospitals we'd be raising payments and margins, but only slightly, and reducing payments and margins slightly for high margin hospitals.

The next overhead is the draft recommendation language. This is the same as the language you saw at the last meeting, saying essentially the Secretary should fully implement the policy in 2002, rather than continuing the phaseout over the remaining three years.

The remaining issue, since we don't have much that we can do about timing of the wage data and there's nothing we can do about the labor market areas in the short run, the remaining issue is dealing with the labor share.

One point about the age of the data. There are a lot of people, a lot of anecdotes, a lot of press about the shortage of nursing personnel these days, and a lot of people have worried about the consequences of shortages and if providers have to raise their payment rates and so forth it won't show up in the wage index for four years.

Really whether that's a problem or not depends on whether it affects different areas differently. If the

shortage is widespread across the country and everyone has to raise their wage rates, it won't change the wage index because it's relative. And it becomes more of an issue of what sort of an update you would have to give to recognize the change in market conditions.

But in any case, there's not much we can do about the timing of the wage index data, even if the shortage problems are geographically spotty.

DR. ROWE: Just following up on that. I think that's an interesting observation. Do we know if the purported or alleged shortage is local or variable? Or is it general?

MR. PETTENGILL: I don't.

DR. ROWE: Is it worse in rural areas than urban areas or vice versa? Do we know?

DR. WAKEFIELD: I haven't seen rural versus urban breakdowns. We've got data from across the country, state data and then regional data, national data from the national sample survey but I don't believe I've seen rural versus urban data, only anecdotal. And that anecdote is pretty

significant on rural hospitals.

MR. PETTENGILL: But you would hear many anecdotes out of urban hospitals, too.

DR. WAKEFIELD: Absolutely.

DR. WILENSKY: One would assume that the inner-city shortages, the difficulties may be worse. Any of the institutions that get stressed at all probably are going --

DR. ROWE: Are less able to pay higher salaries. The hospital with higher margins would presumably be better able to respond to this kind of challenge.

DR. WILENSKY: That would be your guess, but I have not seen any data on that.

DR. ROWE: The ones that have some money left over at the end of the day.

MR. PETTENGILL: Options for the labor share. We talked about the possibility of -- we raised questions about whether all of the components currently included in the labor share really should be there. We don't know the definitive answer to that question. Certainly, I don't. And so the recommendation basically asks the Health Care

Financing Administration to go back and take another look. They haven't updated the wage to the market basket, which is where this information comes from, recently. It's about time to do that.

So the recommendation is not for them to take specific action that would affect payments necessarily. It's to go look and see whether the weights included in the labor share are still appropriate.

Just to give you an idea of what it might mean, we made up a scenario in which the labor share would be reduced from 71.1 percent to 67 percent. But that's just an illustration. That's not because we think it really would end up being 67 percent.

Again, there's nothing that says that this would be budget neutral, but in fact at 67 percent it comes out close to budget neutral. It would reduce payments somewhat for urban hospitals and increase them for rural hospitals. And you can see the numbers in front of you, for low margin hospitals it would raise margins slightly, at least in rural areas, and reduce them slightly in urban high margin

hospitals, but raise them in rural high margin hospitals.

DR. ROWE: It would raise the margins --

MR. PETTENGILL: Would raise payments for high margin rural hospitals, yes.

DR. ROWE: High margin hospitals. If the baseline margin is 22.7 you're giving them 0.5 more, why does the margin go down?

MR. PETTENGILL: Must be an error.

MR. ASHBY: No, it's not an error.

MR. PETTENGILL: Actually it doesn't have to be.

MR. ASHBY: No, it doesn't have to be an error. Sadly to say, the answer to that is that there's a different sample used for the middle column than the right column because not all the hospitals have reported on the margins data. But our change in payments is based on a 100 percent sample of hospitals. So we get a little bit of bias. The one to pay attention to is the middle column, and that one is completely accurate.

DR. ROWE: So how much would we redistribute if we did that? We had $22 million, we had $300 million, we had

$700 million, and now we're up to?

DR. REISCHAUER: I confess, Jack is right, because I left out the urban and the urban went up in one table and not the other.

MR. ASHBY: In terms of the additional spending altogether, which is the kind of number we're talking about here, almost nothing.

DR. ROWE: But how about redistribution?

MR. ASHBY: It is budget neutral, so there's no increased spending.

DR. ROWE: How much would you redistribute?

MR. ASHBY: I don't know. We would have to go back and calculate that. The answer to that is buried in some massive printouts we have, but I don't know.

DR. NEWHOUSE: I'd like to make a comment on the logic here, if I could. It goes to actually the language in the recommendation that says, nearly always. I believe that Wall Street law firms charge higher rates than law firms in Dubuque. Now if I'm a hospital in Dubuque, I may sometimes use the Wall Street law firm. I probably more often use the

Dubuque law firm, but I don't know. The fact that Wall Street law firms and Dubuque law firms continue to exist doesn't to me imply that we should pull law purchases or lawyers purchases into a national index.

What we ought to do is, in principle, which is data we don't have, how often do you buy law services from high-priced or from major metropolitan area law firms rather than locally? Even if you did that 25 percent of the time, presumably that would fall -- by this recommendation you would now take all of the law -- the 75 percent you purchased locally and put it into a national index.

MR. ASHBY: But remember, if we took all of the suspect categories and made them all national we would end up with a 63 percent labor share. For simulation purposes we went with the 67 to represent exactly that notion. The answer is going to be in the middle somewhere.

DR. NEWHOUSE: But how do we know that?

MR. ASHBY: It's going to be somewhere between the top and the bottom.

DR. NEWHOUSE: It depends how broadly you want to

define the middle.

MR. SMITH: And purchases aren't going to be in the middle either, Jack. It's at least as illogical that a New York City-based hospital would purchase legal services in Dubuque as the other way around. So the skewing here is constant rather than moving toward a mean. Putting all of these things into a national marketbasket gets the skewing wrong on both ends it seems to me.

MS. RAPHAEL: You based this on asking national firms and they told you that they charged the same fee. That hasn't been my experience in dealing with technology companies, accounting firms, consulting firms, legal firms. My experience has been that the rates are very locally determined. But I just think that we need to do a lot more work before we could comfortably --

MR. PETTENGILL: That's why we didn't say change it. We said, go back and look.

DR. NEWHOUSE: But you did say, only includes costs nearly always purchased in local markets, implying that if you bought some non-trivial fraction in a national

market you'd put everything into the national index.

MR. PETTENGILL: How would you like to change that? Would you like to change it to generally purchased --

DR. NEWHOUSE: I'd just strike, nearly always; resources that are purchased in local markets.

MR. HACKBARTH: So you would actually split the category.

DR. NEWHOUSE: I'm not really sure the game is worth the candle at the end, but if you were going to do the policy thing I think that's what you ought to do. You ought to take the overall hospital. Things that are purchased locally ought to vary with the wage index and things that are purchased nationally -- now there's Carol's issue about rates. I don't know the answer -- that's a further question. My guess is, if we're literally talking about law firms, that the Wall Street law firm does charge Dubuque what it charges New York City, but maybe not. But there are probably other national firms that do vary their rates, and in principle that should be accounted for.

MR. PETTENGILL: Not only that, there are other

services included on the list that clearly are not local. If you buy computing services these days you don't -- you can get them from anywhere. And if you choose as a hospital administrator to buy them locally, that's no reason why Medicare should increase its payment for that if you can buy the same thing --

It's like hospitals that go out and buy drugs and they get them through a local organization and pay 30 percent more. Should Medicare raise its prices to accommodate that when the same supplies are available through a national market at lower rates?

MR. HACKBARTH: Today the labor-nonlabor split is drawn from the marketbasket. What is the test applied there? If this recommendation is nearly always, what is the analogous test in the marketbasket?

MR. PETTENGILL: That's a good question. I don't know. Basically the marketbasket has weights for all of the price indicators and those are developed from a combination of data from the Bureau of Economic Analysis, their input-output tables, and from AHA data, and there's probably some

1 Medicare cost report data in the mix. But in the end, I
2 think it's a judgment about which weights are considered to
3 be --
4 MR. ASHBY: I think there's another answer to that
5 though. That is that all of them that HCFA has labeled
6 local are local because they are driven by labor that is
7 local.
8 MR. PETTENGILL: That's what their judgment is.
9 MR. ASHBY: Yes. So their judgment is that all of
10 the items, if you will, whether it's a computer service or
11 supplies or whatever, that they are all national. That is
12 their judgment.
13 MR. HACKBARTH: But some of these are clearly a
14 mix of local and national, like legal services. So they
15 have to be applying some test, explicit or implicit, and
16 say, this one's going on.
17 MR. LISK: Let me just clarify it. It's all
18 labor-related costs, what they consider labor-related
19 expenditures are then classified as labor related and then
20 treated as though they are local. So there's no distinction

between local and national in terms of how HCFA develops that weight. They determine what is the labor-related share and that's what they apply the wage index to.

MR. HACKBARTH: So if it involves --

MR. ASHBY: If it involves labor, or if it's a product --

MR. LISK: If it involves labor, the wage index is applied to that share.

MR. ASHBY: It is still a judgment, and probably not overly accurate either.

DR. REISCHAUER: Can I ask another clarifying point about these tables? We have low margin and high margin. That doesn't exhaust the universe.

MR. PETTENGILL: No, we have the middle group as well.

DR. REISCHAUER: There's something in the middle and we're to presume that the effects on them are pretty minimal usually? We care about high and low and you're drawing a distinction, but if there was another panel that said everybody else and we saw a huge leap or fall in them

we'd be very concerned about --

MR. ASHBY: There wasn't, I don't believe, a single case where that was the situation. But we got into this to highlight the low margin hospitals. We put the high in there for balance I guess, but it's an arbitrary choice in a sense.

MR. PETTENGILL: To the extent that we put tables in the report they will have all three.

MR. ASHBY: The next issue has to do with the PPS base rates. The inpatient PPS currently has two base rates, one for large urban areas. That's areas with a population over 1 million. One for all remaining urban areas plus rural areas. This option is to raise the rural-other urban base payment rate to the level of the large urban.

You remember from our discussion at the last meeting that there are arguments both pro and con here and there is, at least in our assessment, no clearly correct answer in terms of improving the rationality of the system. So this is going to be kind of a tough choice.

The leading argument against raising the rural

base payment rate is that our multivariate analysis showed that costs are lower in rural areas after we control for wages, teaching, case mix, and so forth, the other factors accounted for in the payment system.

But at the same time, there's clearly another side to that coin. Our analysis also showed that there is no justification for the higher base rate that we already have for large urban areas. Costs in large urban hospitals are only higher in raw form. After you control for the other factors in the payment system they are not any higher than in other urban areas.

So equalizing the base payment rates would have a mixed result in terms of improving the accuracy of our payment rates. It would get it closer for some groups, farther away for others. So clearly one could justify either move.

But also on the pro side, one might argue that there is an inherent advantage in having a single base payment rate with then a set of targeted payment adjustments to account for factors that have a differential effect on

1 different groups of hospitals. As we've talked about at
2 length, our ability to implement some of those needed
3 adjustments is probably several years away, but that doesn't
4 necessarily take away from the basic point that ideally one
5 would want a single base payment rate adjusted as needed.
6 So there are, in our minds, three options here.
7 One is to recommend no change, and that, as we say, might in
8 part reflect our belief that the other recommendations that
9 we are making will do enough to produce equitable payments
10 between urban and rural and at the individual hospital
11 level. To help inform your judgment in that area, we
12 simulated the impact of several of the leading options that
13 we've been talking about together so that you can see what
14 the combined impact would look like. We'll get to that in
15 just a moment.
16 Our second option is to defer the issue until at
17 least the next cycle and we'd have more information on how
18 rural hospitals and urban hospitals compare financially, and
19 we'd also have more information on the option that we
20 tabled, and that was extending the expanded transfer policy

to all DRGs and returning the savings to the base rates. Because that option is interesting to contrast against this one.

Both of these options would raise the rural base payment rate, and oddly enough, by probably similar amounts. The difference is that this option would in essence be paid for by large urban hospitals proportionately. The transfer option would be paid for by those individual hospitals that have to date profited by being able to transition their patients to post-acute care early in the episode. That would include, of course, some rural hospitals as well as many urban hospitals.

So one is simply a bit more targeted than the other in terms of funding a budget neutral option. Of course we don't necessarily want to rule out the idea that we would eventually want to do both, so we leave that one open.

The third option is to actually recommend equalizing these rates now. We could look at it as a permanent change or we could look at it as a temporary

change pending finalizing these other targeted adjustments. Of course, in Washington, temporary is sometimes measured in decades. But nonetheless, it in theory could be sunset at some point when we have completed other work.

Looking at the impact table, we've looked at this option budget neutral. Obviously it would not necessarily have to be. The main finding here is that this would increase rural rates on average by 0.5 percent. The 0.1 percent reduction on the urban side masks a decline of 0.6 percent in large urban areas -- they're the ones that are paying for this -- and an increase of similar proportion to rural among the other urban areas.

DR. ROWE: Do you know how much money that would redistribute?

MR. ASHBY: Again we didn't add it up, but a fair amount to be sure.

Lastly, wanted to point out that the 0.8 percent increase down in the bottom two groups is the full effect of this recommendation. The diminished effect among the other three groups that you see there happens because some of them

are paid outside of PPS and they are not affected by this change.

So to help you consider whether this is the kind of move that we would need to make we looked at the combined impact of four options that we've been discussing today. Let me say right off the bat, the four were ones that we thought might be leading options in your minds, but there's a whole bunch of different permutations of options that could have been analyzed but we didn't have a whole bunch of time to do this so we picked out a couple to represent the situation here.

So if we can look at the next overhead, the four that are included here, actually they're there; I don't think I need to read them. They're the ones that we have been looking at here. Two of these are, the wage related ones are redistributive. The last two, the DSH and the low volume are assumed as new monies for this analysis. Then the second combination we looked at are these same four plus adding in the idea of raising the rural rate.

So if we look at the table, the key finding here

is that the four policy options in combination would raise rural rates on average by 2.5 percent. You remember I said last time at the last meeting that the gap in inpatient margins and also the gap in total Medicare margins between urban and rural hospitals was about 10 percentage points. In the first column, the baseline already reduces that to eight points. That's the BIPA change that has already gone into effect. These four policy options together would bring the gap down to six percentage points.

Then if we go on to the next table and add in the last one we see, first of all, that the increase in the rural rates has gone from 2.5 percent to 3.2 percent, and the gap between urban and rural falls another percentage point from six down to five.

I guess I would add just parenthetically, if we did this raising the rural base rate not budget neutral it would reduce the gap down to four. And as we talked about last time, our goal was not necessarily to equalize margins here at all, but this is an indication of how much the gap would fall. Most of the remaining difference can be

attributed to the IME adjustment, and of course that's something that's firmly in place and we're not talking about narrowing that gap here at all. So that's the scenario.

DR. ROWE: And DSH to some extent.

MR. ASHBY: To some extent. But remember, we have a proposal for DSH that's in here that eliminates a lot of that difference. So some, but more limited.

DR. LOOP: On that combination 1-2 slide, you don't mean employed physician data. Don't you mean teaching physician hours? What is employed physician data?

MR. ASHBY: You're implying there's other kinds of employed physicians. Perhaps that was not the right word to stick in there, but same option.

DR. LOOP: But before you said teaching physician hours, because not all teaching physicians spend their time teaching.

MR. ASHBY: Yes. In any event, it would be measured --

DR. LOOP: Probably the minority of employed physicians actually teach at all.

MR. ASHBY: That's right. In any event, is it carried at the FTE that the teaching physicians actually are engaged.

DR. ROWE: It's the IME piece is what you're really talking about. It's the number of hours that physicians are dedicated to teaching as opposed to running the emergency room or the coronary care unit.

MR. ASHBY: Right. But to answer Floyd's question, it is carried in terms of FTE physicians. It's not carried in number of people involved, so it is accurate in that sense.

DR. LOOP: That same term is used in the text too, employed physician data. You probably ought to say something else.

MR. ASHBY: Clean the wording up there, okay.

DR. WAKEFIELD: Jack, what on combination 2 is raising that urban hospital rate from 13.6 to 13.8, the margin? What's raising that margin?

MR. ASHBY: That's the other urban. Remember, the base rate is for rural and other urban, so on the urban side

there's a mix of up and down.

MR. SMITH: And you didn't disaggregate, Jack, urban hospital where [inaudible] --

MR. ASHBY: No. We have that data. I guess we were just limiting the number of tables here.

MR. SMITH: Let me ask a question which I know we don't know the answer to, but we've asked a bunch of redistributive questions. What would be the cumulative redistribution of either of the policy packages? We don't which are big and which are little, or we know which are big and which are little. But it seems to me now they could add up to quite a bit. It would be important to know that before --

MR. ASHBY: I think actually it's fair to say that of the four options you're looking at there, only one of them really has a significant redistributive effect, and that's the labor share. So that's where the redistribution takes place. The other wage index is a real tiny change, although it's redistributive too. And the other two policies don't redistribute at all. So it's really little

more than what we looked at with the labor share alone. That's kind of where the action is redistributively.

DR. WAKEFIELD: Jack, just because you can tell me more quickly than I can find it. It's the case that we're suggesting if we adopt the recommendation dealing with the labor share that it be looked at, though the way you have it reflected here in this policy option is that it would actually be reduced; is that correct?

MR. ASHBY: We had to assume something in order to do a simulation. So that's where we came up with the 67 percent labor share, it was kind of in the middle. But as Joe pointed out, we have no idea whether the middle is the right place. We just had to assume something.

DR. WILENSKY: But let me make sure the commissioners understand. The point is really an important one. If we were to adopt package one, we are not saying (B) is actually what occurs. What we would be recommending is that the Secretary examine the difference between this national and local labor and make decisions that put them in their appropriate slot. And that it's only for purposes of

trying to get a sense of what it might look like that he's used this.

MR. ASHBY: Right.

DR. WILENSKY: So if you were to say, let's look at what we call combination one, step B will be what it will be after there's an examination of the national versus local labor distinction.

MR. ASHBY: We'll make that point very clear in the report.

DR. ROWE: So you're really changing (B) to reduced labor share rather than to 67 percent.

DR. WILENSKY: Or not even. It will be to evaluate the modification and it's only -- I think, correctly, for purposes of being able to simulate, you have to assume something. By taking it in the middle, we try to minimize the error. But in fact there's no reason to assume it would be in the middle.

MR. HACKBARTH: How much of the change described on the impact table is attributable to that assumption of 67 percent? That's a big piece of what's here, isn't it?

MR. ASHBY: No, I would say the biggest piece is the disproportionate share actually, which is not redistributive, and that's not budget neutral. I guess the labor share is sort of like the next one in line, if you will, but it's significantly smaller than the DSH.

MS. RAPHAEL: I just had a question about the low volume adjustment. If we moved toward a policy of implementing a low volume adjustment, does that mean that we would need to then consider it in other areas where there also are low volume issues?

MR. ASHBY: Right, I think that it is incumbent on us to continue the analysis in other areas. Next in line, if you will, would be hospital outpatient, without a doubt, an area that we should be --

DR. WILENSKY: I assume you are meaning non-rural.

MS. RAPHAEL: Yes, I was.

MR. ASHBY: I think it's worth emphasizing that. We didn't really see the low volume adjustment as being restricted to rural hospitals either. If there are other hospitals that meet the criteria, including the distance

criteria, there is no reason whatsoever to restrict this to rural areas.

DR. WILENSKY: Again, that's really consistent with what we said is our preferred strategy for making these fixes, is to recognize that we are not currently making an adjustment that would improve the payment by acknowledging that low volume institutions have higher costs. So although it would primarily affect rural hospitals, if there was a low volume institution is what is a non-rural setting, we'll presumably make the same kind of adjustments, and the same with the distance. This primarily is going to affect rural but it's not being done as a "rural fix."

MR. HACKBARTH: Help me sort out the rural and other urban base rate. The basic logic of the system is you have a base rate and then you adjust that for things that are beyond the hospital's control, whether mix of patients, its input costs, et cetera.

Here we have a difference in the base rate that isn't related to that logic. In fact it's an artifact of the system when it was first put in place, and the goal is

to limit redistribution. The original urban-rural differential was put in so that there wasn't too much money shifted around in the system. Gradually we got it down to this, to the rural-other urban differential. But that logic is based not on cost beyond the control of the provider but just a political rationale that we don't want to shift money about.

MR. ASHBY: I would say that's a fair statement.

MR. HACKBARTH: Now, Jack, in describing the logic behind it you said, we do simulations and we see that the costs are lower in the rural-other urban category.

MR. ASHBY: They're lower in the rural category. They're not lower in the other urban category. So that's why I say, the findings don't match the current system already. If there were to be a division, it appears that the right division is urban-rural which is where we started out way back at the beginning. But we wanted to phase that out. Somehow we ended up with this distinction between large urban and other urban, and that distinction does not appear to have any empirical base.

DR. WAKEFIELD: Could I ask a follow-up question? If I understood it correctly, Jack, did you also say that there was no justification for the higher base rate for larger hospitals?

MR. ASHBY: Large urban. That's not larger hospitals, that's large urban areas.

DR. WAKEFIELD: That's what I mean, large population hospitals.

MR. ASHBY: Exactly. The multivariate analysis does not support that distinction at all. There is no difference in underlying cost between large urban areas and other urban areas.

DR. WILENSKY: But there is between urban and rural.

MR. ASHBY: Right.

DR. WILENSKY: So the only question is really whether we do something about the other urban.

DR. WAKEFIELD: And if you do something about the other urban, what impact does that have on the urban?

MR. ASHBY: If you did something on other urban

alone it would have no impact, obviously. If it was budget neutral it would have a negative impact. But I guess we were assuming that we were not going there. That if we made any change at all it would be to get to a single rate, which has a certain intuitive appeal, to simplify the system. It would be one less border in the system if we had one rate here.

DR. ROWE: Just for the sake of trying to blind justice, if the data that we're given are correct, and if rural hospitals have consistently higher total margins than urban hospitals, why is it beyond thinking that you would actually distribute money from rural to urban? I'm not suggesting we do that, but everybody says, we can't go there. It seems to me that if in fact that data we're given are correct, that if that's something that we wanted to discuss, we should discuss it.

DR. WILENSKY: That's true of total Medicare margins.

DR. ROWE: No, total hospital margins.

MR. KERNS: That's not the case on the overall

1 Medicare.

2 DR. WILENSKY: We're trying to impact what

3 Medicare is doing, and in the same dissertation that we

4 didn't want to, or had some reluctance about making up for

5 some bad decisions of the private sectors in urban areas, I

6 don't know that we want to penalize rural areas for being

7 able to cut good deals because of their positions in rural

8 areas. What we're trying to do is get Medicare payment

9 right and to make what are good Medicare arguments.

10 DR. ROWE: I accept that. I think that's the

11 right answer. But for me at least, the difficulty in

12 looking at this, Gail, relates to the fact that the factors

13 that regulate the total margin of the hospitals sometimes

14 are unlinked to the factors that are driving the Medicare

15 margins of the hospital. Let me give you an example that

16 I'm thinking of.

17 Many of the rural hospitals -- now I'm putting my

18 health plan hat on. I have a lot of hats here, but this is

19 the health plan hat. I'm serious about this though, and

20 maybe the economists can tell me where I'm wrong.

The rural hospitals do very well with the health plans. The data and the figures in this chapter, the health plans pay the rural hospitals 140 percent of charges -- or costs, 140 percent of cost according to these data. I think they do that in part because the plans need to have access for their members to the hospitals, there's no competition, no other hospital so there's not really a market. That is a large part of making the total margin for the rural hospitals higher than the total margins for the urban hospitals.

Now if we say we want to raise the Medicare payments to make sure that the total margin for Medicare for rural is equal to that of urban or is equal to zero, that's not going to reduce the advantage that the rural hospitals have with the health plans. They're not going to stop getting 135 to 140 percent of cost. What's going to happen is the distance between the total margin of the rural hospitals and the urban hospitals is going to get greater because of this lack of -- I mean, that's what I see as somebody who's focusing more on the total margin.

1 So if we wind up doing something like this, and
2 any one of these or more of them -- and I'm not commenting
3 on any of these in particular, I was just thinking about
4 this. That because of this effect we're going to wind up in
5 two years coming back the difference between the total
6 margins is even greater. We have to think of that as well
7 as the Medicare program.
8 I think if these hospitals have high positive
9 total margins then our Medicare beneficiaries are going to
10 have access to these hospitals. The hospitals are going to
11 be there, they're going to be sustained, et cetera.
12 DR. WILENSKY: But we still want to make -- to the
13 extent that we make adjustments that we think -- to the
14 extent that we make recommendations to change Medicare
15 payment in a way that we believe improves the accuracy and
16 validity of the Medicare payment, like making an adjustment
17 for low volume because costs are higher in low volume
18 institutions, that is something that we ought to be
19 comfortable making because it makes for a better payment
20 system. I think we ought to hesitate from making

1 recommendations purely because of the effect they have on
2 margins if we don't believe it is an improvement to how
3 Medicare pays.
4 Now at the end of the day when we have what we
5 think are the best Medicare payments, if we think there are
6 areas where there will be access problems for seniors, then
7 we have a different issue. But I don't think we should not
8 do something when we think it will make for a more accurate
9 Medicare payment. Now the fact that it may alleviate what
10 we think are some other pressures, fine.
11 But we really can make the justifications why --
12 I've tried to raise this several times during the day, is
13 that, in my view, based on what we've said as a commission
14 before, we ought to be looking at changes that improve
15 Medicare payments. And we ought to look at the
16 distributional effects between whatever groups that we think
17 are relevant -- and this is supposed to be focusing on
18 rural. So obviously the first question is, if we're making
19 what we think is a better payment, what does it do for rural
20 hospitals, and which rural hospitals, and how do we feel

about that?

DR. ROWE: I would only say, I accept that and I think it's consistent with what I'm saying also. I guess I would just complete my thought, Gail, by saying that I think that that's right but that in doing that and making those adjustments to improve the quality and fit of the Medicare payments, we should be mindful of the effects on the individual hospitals.

And since the groups of hospitals overlap so much in their characteristics with respect to how they're doing on these margins, Medicare or others, as Julian has pointed out, if the change you're going to make to target some of these identified inequities or weaknesses in the Medicare payments, irrespective of the effect it's going to have on increasing the overall margin of the hospital, is also one of redistribution -- of moving money from some Medicare hospitals to other Medicare hospitals -- that even further aggravates what I see as this overall margin effect because it lowers urban as it raises rural.

That doubles the effect. And I see that as

probably not worth the candle. It's kind of, above all, do no harm. That's different than some of these targeted recommendations that have come along that we've heard today which we'll get to, which are more targeted toward the real needs of the Medicare program toward some of the rural hospitals, rather than all of them.

DR. WILENSKY: Again, I think we're going to go through each of these recommendations and we'll have an ability to either accept or not accept the recommendation on its own merits. I think trying to look at, when we look at several of these in combination, what do we do or what impact that we'll have I think is fair.

MR. SMITH: I think the logic of what you and Jack just went through is right, Gail, but I think it's a mistake when we're looking at recommendations that are redistributive to think that our only metric of change ought to be rural hospitals.

I think part of what we need to be concerned with is the maintenance of the hospital infrastructure that provides support to Medicare patients. It's not obvious to

me that if we weaken it in urban areas by reducing total margins and improve it in rural areas by increasing total margins, that we shouldn't look at total margins, at the impact of the Medicare system on total margins to the extent that that has an impact on the stability and viability of the institutions.

DR. WILENSKY: I think that's fair. The fact is unless we're just talking about putting more money into the hospital area -- and we have, at least in terms of our previous recommendations believed that the current payment, payments in current law were adequate, that looking at some of these specific issues and seeing whether or not there's a better way to focus Medicare payments is an appropriate exercise.

I think that was why the impact on total margins for urban and rural, and if there are other hospitals that you want to look at we can at least try to provide you with that information in the interim, is appropriate. We're not just looking at how it affects rural, but we are giving more attention to how it's affecting rural. There are categories

1 to show otherwise.

2 Now we know that, or we all understand that in

3 Medicare as we currently have it structured, that the DSH

4 and the indirect medical education, the GME payments,

5 produce very high Medicare margins which help have total

6 margins that are at least in the positive range for the very

7 large urban hospitals. I think we all realize that because,

8 particularly of the function they play in the aggregate of

9 the uninsured, that whatever our views about how effective a

10 targeting mechanism that is, there is a particular

11 relationship going on and we're not anxious to have a major

12 change in the distribution.

13 One of the fortunate factors is that you can do

14 more to change the rural because they're not only a small

15 proportion of the hospitals but they tend to be typically

16 small hospitals, so that in doing something that improves

17 accuracy, that has some beneficial effect on rural, you're

18 tending to have a very small effect on urban because of the

19 relative dollars that are accounted for. I think it's fair

20 to say if you're having redistribution, you ought to have

1 some idea about where you're redistributing from as well as
2 where you're redistributing to.
3 MR. HACKBARTH: If there's a change that makes
4 sense within the logic of the system that has a
5 redistributive effect away from urban towards rural, I hope
6 we'll go ahead and do the change --
7 DR. WILENSKY: I agree.
8 MR. HACKBARTH: -- because it's logical; it
9 perfects, improves the accuracy of the payment system. If
10 we get to the point though, Jack, where these changes have
11 driven urban hospitals into financial distress, looking at
12 the total margin, then I think the appropriate response is
13 to take that into account when we do the update factor. Not
14 to forgo improvements in the system because they have a
15 redistributive effect.
16 I think that if we look at the total margin as
17 sort of a fallback; yes, we have to assure there's an
18 adequate infrastructure for our Medicare beneficiaries. But
19 our principal responsibility is as a payer for Medicare.
20 But we don't want to drive all the urban hospitals into

bankruptcy, and if we need to do something, let's do it through an update.

DR. ROWE: Let me respond though. With all due respect, I think we have different points of view because we've spent our time doing different things. I think your suggestion is, if we do this and it drives the hospitals into distress and financial crisis, then we will correct it with the update factor, is a policy-oriented, inside-the-Beltway point of view. As a guy who has run hospitals and had to fire people and close units and reduce services as I go into distress, only then to have Congress respond and two years later I get some more money so I can open the unit again, that's no way to run a community resource.

MR. HACKBARTH: But the rural hospitals would say the same thing.

DR. ROWE: I know they would. I'm not suggesting that this is urban versus rural. I'm just saying that the way to run policy, if we want to have sustainable resources for our Medicare beneficiaries to get access to high quality care is not to say, we'll do this and if you go broken then

we'll change and we'll give you some and we can resuscitate you. We need a sustained system. That's all. It's just a philosophical --

DR. WILENSKY: Let me try to remind people, first in terms of the relative magnitudes that we're talking about. I think people are getting totally off the base of anything we're talking about. We have been talking about relatively small changes that mean more for the rurals because they account for 20 percent of the hospitals and 10 percent of the dollars or less or whatever. I mean, we're talking about rather modest change.

The second thing is the kind of statements we made for the rural apply for the urban, which is that if at the end of the day we have had the best kind of payment policies that we can come up with and we think there may be problems, then we ought to feel comfortable about recommending non-Medicare solutions to address the problems. Now I don't think we are anywhere near that. I think people are getting into arguments and corners without thinking about the numbers that are involved here.

But just as we said several times about rurals, that there are things that are appropriate for Medicare to do, and there may be other issues that are perfectly appropriate for public policy that go beyond Medicare, certainly are appropriate to say for the urbans.

But what we're trying to do on the changes we've been talking about thus far is, is do what we believe are improvements. And to the extent that the policy issues come up which we don't think are justified on policy grounds, and some of the wage change, the floors and the wage indexes would fall into that category, then we think they're not appropriate policies.

I don't think we're talking about redistribution of the level that you're raising, but again I think that if we find that there's any change and we think any change has a negative impact on urban hospitals and it's Medicare's place to make sure there's no -- anything we do is budget neutral with regard to urban hospitals, that would put a burden that I think we have not held when we went the other direction.

MR. ASHBY: Can I interject here that we have two small potential improvements that don't necessarily increase rural margins as well still on the table that we wanted to go through too, when the appropriate point is --

DR. WILENSKY: We're going to come back to do each of these recommendations, so unless there's -- to review them. Is there something that you want to say at this point?

DR. WAKEFIELD: It was just basically the same points that you made, Gail. If you hadn't have made them, I would have made them, for the record. In the interest of time I'm deferring.

MR. KERNS: I'm just here to revisit one subject we spoke about at the last meeting and to raise one more. We have some new data that may inform your decision regarding the rural referral center recommendation we spoke about last month.

To refresh your memory, rural referral center receive waivers from two of the three rules for reclassification. One, they don't have to show proximity to

the area they want to relocate, and the second, they don't have to show that their wages are in excess of 106 percent of their actual area's wages.

If these hospitals really do employ a more expensive staff mix, as how the program was based so that they would have a higher staff mix, then their higher cost should result in wages above the threshold required for reclassification. We found that in 2000, 50 percent of rural referral centers that were classified to a new wage index had wages that were below 106 percent of their area's average, and therefore qualified for reclassification based solely on this special exception.

Based on the inequality suggested by these numbers, you may wish to recommend that the Congress require rural referral centers to make the same wage thresholds as other hospitals for reclassification, but retain their waiver of the proximity rule.

As a compromise measure, you could consider requiring that rural referral centers have wages that are at least above average for their area. We found that nearly

one in four, 23 percent, of reclassified rural referral centers, when they were sent to a new wage index had wages below the statewide rural average. So they were already receiving payments favorable to their facility's costs.

With this refinement, those rural referral centers that meet the rationale for different treatment, having higher resource costs, would continue to be reclassified, and those that don't would not.

This next one is the sole community hospitals. At the last meeting I reported that the critical access hospitals are not counted as like facilities, similar hospitals, in applying the 35-mile distance test for applicants to the sole community hospital program. With the steady increase in the number of critical access hospitals from 219 last fall to over 350 today and the promise of more to come, the Commission expressed concern that the number of sole community hospitals could also increase dramatically, and possibly unnecessarily.

We analyzed road mile distances to the next hospital and found that when we include critical access

1 hospitals only 45 percent of sole community hospitals are
2 more than 35 miles from another hospital. The number of
3 sole community hospitals increased by 75 in the last year,
4 and it may begin to increase at a further rate. Right now
5 nearly 1,200 rural hospitals, which is more than half of all
6 rural hospitals, are either sole community or critical
7 access.
8 In discussions with HCFA I've heard that the
9 number of sole community hospitals could increase because
10 there's a growing interest of hospitals calling in and
11 asking about the rule, and hospitals wanting to collaborate
12 together in application for these programs, et cetera.
13 DR. WILENSKY: But either we believe that the
14 critical access hospital definition has some meaning, in
15 which case they're not similar hospitals. I find that
16 either we don't really mean that they're similar hospitals,
17 or we think that somehow the critical access hospital is a
18 phony distinction, in my view. That if these aren't really
19 hospitals any more, they're medical holding centers. Then
20 it strikes me that saying that you have in your presence a

medical holding center still means you're a sole community hospital, because by definition medical holding centers aren't going to be community hospitals. That's what they pledged when they became a critical access hospital.

MR. ASHBY: They still provide inpatient care there's just kind of a slow continuum of what inpatient care means that's very wide, and where to draw the line --

DR. WILENSKY: Clearly, the Congress decided they're not community hospitals, that's why they're giving them the special privileges of being critical access hospitals. We can argue about this. Either you don't believe that a critical access hospital is a real entity, or if you do then it strikes me that this isn't logically consistent.

Although I understand the concern that you're raising of, are these almost hospitals. If they're almost hospitals, we ought to be asking why we're giving them the special privileges of being critical access hospitals. So either you don't buy into the special support that critical access hospitals are given or it doesn't seem to me that

this really is supportable. You can decide which direction that you think is most appropriate.

MR. ASHBY: I think we're at the end of the list if we want to backtrack.

DR. WILENSKY: Why don't we go back to the recommendations. I apologize for making people wait so long in doing the recommendations but we frequently trip on the fact that it's coming later argument when we do them one at a time. The first has to do with disproportionate share. This, as you will recall, was to take at least one step further where Congress had gone on having a similar threshold but having a differential cap.

DR. ROWE: Could we have with each of these some understanding of the financial implications?

DR. WILENSKY: This is an add-on cost.

MR. ASHBY: Right, it's on the order of $180 million or so cost.

DR. WILENSKY: This was basically consistent with the recommendation that we made of which Congress adopted part.

MR. ASHBY: Right.

DR. WILENSKY: So we're effectively reiterating our previous recommendation, somewhat modified.

MR. HACKBARTH: When Congress went, I think you said a third of the way last time, was it just for budget reasons that they only went a third of the way or was there some other logic behind it?

MR. ASHBY: No, it was largely for budget reasons. We argued that if you have a cap on how much you can spend, better to at least make the qualifying criteria equal and cap it at the very high end. But in the end it was a budget decision.

DR. WILENSKY: Any changes to the language?

DR. REISCHAUER: Not to the language, but I presume our end objective is to eliminate the cap altogether at some point.

MR. ASHBY: Right.

DR. REISCHAUER: I would hope that in the text at least, or in the wording here, that it would say, for the time being raise this, rather then some --

MR. ASHBY: We tried to make that clear. This is taking us towards a final goal, and we're not forgetting the final goal.

DR. WILENSKY: Also the change that we want to have uncompensated care included as the appropriate trigger.

DR. NELSON: I wasn't here when the decision on the 10 percent figure was made. Why was it 10 instead of nine or 11?

MR. ASHBY: It about cut the difference one-third/two-thirds. There was also the thought that 10 percent is a figure that's already in law. That is the rate that is available to sole community hospitals which make up a third of the rural hospitals. So by making it 10 across the board we've at least created some consistency across all rural hospitals, until we get to the next step when there wouldn't be a cap at all. But even having said that, it's not like it's a scientifically determined, correct number.

DR. WILENSKY: Any further discussion on this?

All in favor?

All opposed?

All not voting?

Next recommendation? My understanding was it should read that Congress should require the Secretary to develop a graduated adjustment is the words that should be in there?

DR. ROSS: Yes.

DR. WILENSKY: So insert that phrase.

MR. HACKBARTH: Say again, Gail.

DR. WILENSKY: The Congress should require the Secretary to develop a graduated adjustment.

DR. ROWE: This is the $22 million one, right?

MS. ROSENBLATT: Is this with or without the miles?

MR. ASHBY: We were looking at that as a separate recommendation, but want to include that, too.

DR. WILENSKY: Is there a reason not to put them together?

MR. ASHBY: It was only the thought that there's two decisions here. One is whether the low volume concept

makes sense, and then secondly, whether you want to make it uniformly available or create an access to it. I think if you approve both concepts then it only make sense to go back and fold them back into one recommendation.

MS. ROSENBLATT: I was taking it as an either/or.

DR. NEWHOUSE: No.

MR. ASHBY: We had it as two essentially because you can have one without the other. But if you want both, then let's fold it into one recommendation.

MR. HACKBARTH: Put it as one, because I don't support the first one without the second.

DR. REISCHAUER: I don't want one without the other.

DR. WILENSKY: Is everybody comfortable putting the two together?

DR. WAKEFIELD: I have a question. Jack, what does this do to the discussion you had in the narrative about one option could be to split the low volume adjustment if you had two hospitals that were within somewhat the same area? Does that factor in here at all or no?

MR. ASHBY: Yes. We suggested that that was the way to handle hospitals that are closer than 15 miles. So if your recommendation has the 15-mile standard in it, then the backup language would explain that that's the appropriate way to treat those that are less than 15 miles. In theory, I guess you could bring that up to the bold level of the recommendation two, but somehow it seemed like more of a detail level for supporting language.

MS. NEWPORT: I'm not sure, maybe it's just we've been on this so long, but the weather conditions, is that defined already as something that's --

MR. ASHBY: Those are already built into law for sole community and critical access where we have mileage things. So I guess it was kind of a matter of bringing that up quick enough when you implement the standards.

DR. WILENSKY: But this is a phrase of art that's already in law.

MR. ASHBY: Right.

DR. WILENSKY: Is everybody comfortable then amending the recommendation that we just made to include the

qualifications of this?

DR. ROWE: Thirty-five miles apart.

MR. KERNS: It would be road miles.

MR. LISK: I think the only thing is whether you want it to be specific on a mileage or not, or just leave that as it is here in the discussion.

DR. WILENSKY: Are we comfortable in leaving the wording as it's there?

Okay, let me have a formal vote of all voting yes on this, as amended?

All voting no?

All not voting?

Thank you.

DR. ROWE: On this next one, I may have missed the discussion, but can you give me just a minute on the certified registered nurse anesthetists? Why are we taking out certified registered nurse anesthetists?

MR. PETTENGILL: Because they're paid under Part B.

DR. WILENSKY: Any comment about the recommendation?

All in favor?

All voting no?

All not voting?

All right, the next recommendation?

DR. LOOP: I was just pointing out to my learned colleague here that the CRNA cost and the CRNA reimbursement for education are not the same, reimbursement for training. So I don't know whether that's true across the country, but they ought to take a portion of that that is reimbursed and delete that rather than taking away all CRNAs.

DR. ROWE: For his institution, the cost, he gets Part B for it.

MR. ASHBY: But remember, the only thing that is at issue here is not the payment but their salaries as a mechanism for measuring prevailing labor conditions in the area.

DR. LOOP: I thought it was just for Part B reimbursement.

MR. ASHBY: They are paid under Part B, but what we pay them isn't the issue here. It's their salary rates when they are employed by the hospital that's the issue here. HCFA's thinking was, if they're not going to be paid under the Part A system then why have their salaries helping to calculate the average wage rate for the area.

DR. WILENSKY: This was not in terms of their reimbursement. This was only in terms of whether to count that salary as part of the wage rate adjustment. We'll have the vote amended.

The next one, Joe had requested that we delete the nearly always phrase in front of purchased at the end, and also to have the Secretary should reexamine as opposed to carefully reexamine.

MR. SMITH: Joe's changes go to part of my concern. I think this one, Gail, fails your test of decent Medicare payment policy and falls into, how do we shove more money in one direction. Joe had raised the question earlier of an inappropriate geopolitical tilt in some of the recommendations. I think this one has that.

I like the first option at the beginning of Jack's slide which was, do nothing. I would prefer -- we don't have much evidence here that costs are misclassified. This is redistributive in a way that we don't fully understand, and it doesn't have much to do, based on anything that we know, with good Medicare payment policy. Now maybe a careful reexamination would help get us there, but the wording of this is suggestive of an outcome that I don't think what we know justifies.

DR. WILENSKY: I appreciate the concern you're raising. As I read this recommendation, I don't see that it says that, so it would be very important what would be in the text. But as I read this recommendation now it says, the Secretary should reexamine the cost in the labor share to ensure that each labor share only includes cost for resources that are purchased in local markets. I don't see anything wrong with that statement.

DR. ROWE: Yes, but, Gail, the discussion that we had about this revolved around a model that was present of an estimate of what kind of change would occur, so that's

what we're basing our responses on. It's not like we didn't have the discussion. And when we asked how much the redistribution was it was said, we don't really know, it's buried in the data somewhere. Until we know that I sort of feel as David feels.

MR. SMITH: I think the problem here is there's no reason to ask the Secretary to reexamine unless we think there's a problem that ought to be fixed, and the discussion in the text suggests that the problem is a problem which could be fixed by redistributing from urban to rural. I don't think that case is made, and unless it's made I'm not sure why we would ask the Secretary to reexamine something.

Then the example we have, which further buttresses the presumption that this index is wrong is an example that would result in a 4 percent shift, or a 4 percent reweighting, which would result in an unknown shift having unknown consequences. I just don't think we're there.

MR. HACKBARTH: I would not support going to 67 percent because it's in the middle. I do think that there are a number of anecdotes or reasons why you might suspect

that the current allocation is not the right one, because as Craig said, it's an absolute test now. If there's any labor involved it's considered to be local. We can all name a half-dozen examples off the top of our head what that assumption would not be an accurate one.

So I'm not sure what the outcome would be, and we're not suggesting that the Secretary just implement something. We're saying, we need more information to evaluate whether this is in fact a problem or not. If we don't get more information then we're going to be in a position where a policy judgment is made without any data.

DR. ROWE: We can get more information without the Secretary getting more information.

DR. WILENSKY: We do those kinds of recommendations, ask the Secretary to look at something because we think there's an issue. We did that when talking about our disproportionate share discussions last time in terms of the distributions.

I think that we're going to have to go back -- if we adopt this, we have to go back and make sure that the

text supports the discussion, which is that currently the presumption is any labor is local labor. Now that is an extreme assumption, and the question of trying to assess empirically under what conditions these kinds of issues become relevant and how to try to deal with them strikes me as appropriate.

So I think that the text discussion needs to follow the sense of what was raised. But I guess I don't see that what we're asking the Secretary to do in the text is inappropriate.

DR. ROWE: I don't see that either from that point of view, Gail. I guess to reiterate my earlier point, I don't want to be cast in taking a position that all labor is national or all labor is local, and there are many distinctions and examples that we could give here that we all have. I mean, that's silly.

DR. WILENSKY: But that is where we are now.

DR. ROWE: I understand that. I'm thinking about why are we doing this at all? You've heard what I have to say about overall margins and Medicare margins, et cetera,

and if that's what we're trying to fix my view is there isn't a problem there.

MR. ASHBY: No, we originally got into it because we really thought that there was a good chance that the shares were inappropriately defined now when you really think about how these markets work. On both the labor side and on the profit it seemed --

DR. ROWE: You can't give us any estimate of what the redistributive effect would be?

DR. WILENSKY: He's not at this point not even saying what the error is.

DR. ROWE: No, but we did have presentation for half an hour of a model. What would be the effect of that model? We don't know. How can you ask us to vote if we don't have --

DR. WILENSKY: Because we're not asking to recommend 67 percent. We're asking to go back and look --

DR. REISCHAUER: What we're asking is, do it better than it's done now. We know it's wrong. The better might be a very marginal change after the Secretary looks at

it, or it might be 67 percent even, but I doubt it. I think it's probably going to be a very, very small change.

DR. WILENSKY: But we know what we have now is wrong.

DR. WAKEFIELD: I think wage index in total is a very serious issue, not just for providers in rural areas to try to get a handle on what's going on with it, but it is also for policymakers. It is a big, substantive topic of discussion. The more light we can shed on what the component parts are that may or may not be problematic, I think we do a service to both policymakers and to providers. Some of the researchers that I talk to say that this is probably one of the areas that is really off, but all we're doing is talking in anecdote until we've got good data.

In part what I hear, and I guess it's just me now and the hour, but it's somehow saying we shouldn't look at this, even though we're going to be informed if the Secretary is looked at it. For some reason the Secretary shouldn't examine it, when we're quite certain that there are problems, but we don't have good information about the

magnitude of those problems. So I'm having a tough time with the difficulty of this, I guess I'll say, and I'll just get to the point which is, I support the recommendation minus the word carefully.

DR. STOWERS: I'm going to be redundant on purpose, and that is to say that we know we've got a problem here. Mary, I agree, we need to take a look at it. I agree with not setting the 67 percent. But to those in the rural areas, obviously this needs to be looked at and we need to do it.

DR. WILENSKY: Julian, do you want to say something?

MR. PETTENGILL: I want to just point out two things. First, the 67 percent was nothing but an illustration. It was only a means of giving you a sense of scale.

MS. RAPHAEL: But how did you come to that, Julian, because it wasn't clear in the text?

MR. PETTENGILL: I came to that by recognizing that the proportion of labor costs that is attributed to

wages and salaries is 63 percent. The remainder from 63 percent to 71.1 is these categories whose origin, whose relevant classification is uncertain. We split the difference, taking 67 percent just to give people a sense of the scale of what changes in the labor share might produce. Not to indicate what we thought would really happen if HCFA reexamined the weights.

The second point is that HCFA reexamines the weights every time they rebase the marketbasket, which they do periodically. It was due this past year. They deferred it because they had a new Administration coming in and didn't have somebody at the top of HCFA to make decisions. So presumably they will be doing rebasing the marketbasket quite soon.

When PPS was first implemented, the labor share was 74.1 percent; not 71.1 percent. It has changed twice as a result of rebasing the marketbasket weights. This is not something that is extraordinary. It's happened before. And it's not out of bounds to think that the assignment of the components wouldn't change again with reconsideration.

That's all. The recommendation is, take a look.

DR. ROWE: If what you're saying is they take a look automatically...

MR. ASHBY: Yet their assumption all the way along for the whole 15 years has been all labor is local. It still has driven their thinking all the way along.

MS. RAPHAEL: Maybe that's right.

DR. WILENSKY: That is why it's two different things. They will do a reassessment. But we're saying also, reconsider the assumption that you've made that all labor, by definition, is local. Have this be empirical, not an assumption.

MR. SMITH: Gail, just to make sure I understand the assertion that that's the assumption. As I look at Table W-7 which deconstructs the labor shares, it seems to me that some of what's listed as national has clearly got a labor component in it. Non-medical professional fees, that's not laborless. Neither is business services.

So maybe I'm misunderstanding something, but if you go to the table in the back that deconstructs the index

1 what you find is that the assertion that everything that's
2 got labor in it is local simply isn't true.
3 MR. ASHBY: Are you sure you're looking at HCFA's
4 assessment or our assessment?
5 MR. SMITH: I may have misunderstood the footnote
6 and the reference to the table, Jack.
7 MR. ASHBY: The national one was us suggesting
8 that this might be something less than all local. By the
9 same token, we weren't going to say it's all national
10 either.
11 MR. SMITH: I'm sorry, I misunderstood your
12 reference.
13 DR. WILENSKY: Again, I want to reiterate that
14 what we're suggesting here is that just as HCFA reexamines
15 empirically the share, that HCFA reexamine the assumption
16 that is made. I'm a little surprised at the vehemence, and
17 I'm thinking this is vehemence without empirical basis,
18 because we don't know what the number is.
19 MR. SMITH: I think it would be my concern, Gail,
20 and I appreciate the concern about our anxiety. I think

1 context matters a lot here. In the context of two months of
2 discussion about rural-urban disparities and a whole day
3 spent on a series of efforts to move money into rural areas,
4 which I have no quarrel with, we have a recommendation which
5 is redistributive and large and unsized and unargued.
6 Now I don't want to argue against good information
7 and more data. I think the context in which we're asked to
8 vote on this suggests that we're for a recalculation that
9 would result in a redistribution between urban and rural. I
10 don't think we're prepared to do that.
11 DR. ROWE: I'd like to say, since I've just been
12 accused of working in a data-free environment I'd like to
13 respond to you, Gail. I think I'm where David is. I mean,
14 how can we say we're against better analysis? That's not
15 what we're trying to say.
16 What we don't want to say is that MedPAC supports
17 changing to a new distribution here based on a new analysis
18 irrespective of the implications of redistributing an
19 unknown amount of dollars from an unknown set of hospitals
20 to another unknown set of hospitals, right, David? If we

can be clear about that, fine. But my concern is that --

DR. WILENSKY: Where is it that you're -- I agree, I would certainly not support such a recommendation. Where is --

MR. SMITH: But the recommendation doesn't exist on the moon, Gail. The recommendation exists in the context of this chapter and this discussion. Perhaps if we wanted to rewrite it to say questions have been raised and maybe we ought to hire a contractor to look at --

DR. WILENSKY: What we're requesting is that HHS, in its multibillion dollar activities, needs to look at this issue. That we think that the assumption that all labor is local, which has thus far been a part of this calculation, isn't appropriate and that it ought to be part of the empirical analysis.

MR. HACKBARTH: I assume the text will say something like Julian just reported, that this is a normal thing.

DR. WILENSKY: Part of it is normal. The reexamination of the amount for labor is normal.

MR. HACKBARTH: And it hasn't happened -- it's a point of concern or contention and we recommend that the Secretary take a look at this and give us some more data.

MR. SMITH: If it's normal, why do we need to make a recommendation?

DR. REISCHAUER: If I'm not wrong, these are national weights, and the Secretary is going to go in and see how much is purchased locally and how much is purchased nationally, and the ending weights are going to be dominated by the urban areas, which in fact are the national weights right now. I don't think there's going to be a huge change when you finish all this.

I think it's going to be a lot of work. And I think probably what we should be saying is something like, the Secretary should do an analysis of this problem to see -- first of all, to see whether this is going to end up being a significant thing at all. My guess is it's not going to be, just because the urban areas, their prices are close to the national averages and they're determining these weights anyway.

DR. WILENSKY: I think it well could be in some ways too bad, although it's not an inappropriate assumption, that the splitting for illustrative purposes, that that decision was made rather than 10 percent off of where they are for just the reasons that you have suggested. But what I see us recommending is that when the normal course of reexamining the labor share occurs, that this assumption -- that some empirical work be done to test this assumption about local versus national weights.

While I think that's appropriate and consistent with the kinds of recommendations we make to improve payment all the time, I think it's particularly important to deal with this right now for political reasons -- political reasons to try to get better policy, not political reasons in terms of just bowing with the wind -- in the sense that this issue is of great concern to the rural areas. What we're suggesting is that it ought to be informed with some empirical analysis as opposed to having arguments based on gut beliefs that aren't informed with empirical analysis.

We've heard this notion of, is it mostly in a

national market, is it mostly in a local market? Rather than rely on anecdote, what we're saying is that we ought to have some empirical analysis and shed some light on this.

MR. ASHBY: It's only fair to point out that we do have some rural groups running around arguing how extremely low their labor shares are and how the system discriminates against them and so forth. That's all sort of dataless as well. We tend not to just believe that at face value any more than the rest, but there is certainly a lot of opinion in that direction.

MR. HACKBARTH: I assume that the text of the report will not include the modeling of the 67 percent, because that was just grabbed out of the air. I'd second what Gail said. I think if we don't address things like this with better information, then we run the risk that Congress, faced with the anecdotes says, we'll impose 67 percent just as a compromise between 63 and 71, and I think that's bad policy.

It's something that should happen in the normal course of events and it hasn't. I think it's entirely

appropriate for us to say, we need to get on with this or something uninformed by data could happen.

DR. WILENSKY: I do think that this portion of the discussion -- we need to go ahead to see where the commissioners stand on this issue. But it certainly needs to be reworded in terms of the discussion so that you can reflect the kinds of issues that have been raised here.

All right, the recommendation to delete carefully, to delete nearly always, is how the wording stands now. Are there any other changes people want to propose?

All voting in favor?

All voting no?

All not voting?

Then are you comfortable that you have enough guidance on what goes into the recommendation?

MR. ASHBY: Yes.

DR. ROWE: Now that we've voted, I think that David and I had not discussed this issue previously [inaudible] It can't be that the two of us were both completely whacko. There was a sense that in some of the

discussion or the modeling or the example that was given or something that this was something that MedPAC knew that this was redistribution, we knew how much money it would be, and this is our model, this is our proposal. There was a sense -- now maybe we were the only two people that got that.

DR. WILENSKY: It was unfortunate that because an illustration was chosen that involved a large number, although as Bob just suggested that when you think about what the weights are going to be, the fact is they're going to be dominated by what goes on in the urban area because that's where the weight is. And unless you think that somehow when you try to calculate national versus local that really is going to skew that a large amount, which is very unlikely -- I mean, it's probably instead of 71 it might be 70 or 69.5.

DR. ROSS: Let me add a coda to that too, because as David pointed out, the flavor of the discussion or the simulation is how can we shovel money from one group to another? Remember the criteria that Jack laid out at last month's presentation -- Jack Ashby -- of the options that

we're bringing to you include things that staff would recommend as well as a number of options that are out there on the table because they are being discussed on the Hill. We simulated them so you could see what they do, and didn't necessarily make a recommendation.

So a number of those options that look like they're just taking money from Peter to Paul, those are being discussed. That may have colored some of the discussion when in fact that wasn't the intent of this particular policy.

DR. WILENSKY: It was, as much as anything, to give you some rationales to why we were concerned about this when our focus has been how to try to get the best Medicare payment that we can, and then if we think there are other problems that need to be addressed, decide how we want to address them.

The option for the base payment rates of rural and other urban areas.

My recommendation is that no more paper come to the commissioners without having page numbers on it so when

we want to refer we can know how to refer.

It's right on the page after the draft recommendation we just discussed.

MR. ASHBY: Again, we didn't put this in a draft recommendation. It wasn't to that extent yet.

DR. WILENSKY: I understand. At the moment it seems like I would be with number one. My sense is that we're not doing anything now. That we believe that we are doing recommendations at this point in time that will improve the Medicare payment, and that at least with regard to these other two we're not in a position where we're interested in making these other recommendations.

MR. HACKBARTH: I agree that this isn't the time to do something on this. I was curious though as to number two and why this was explicitly linked to the expanded transfer option. How are they connected?

MR. ASHBY: As we said they're parallel in the sense that both would raise the rural base payment rate, and how they differ is in how it ends up being paid for. So that raises another option for --

DR. WILENSKY: But we can take that up next time.

MR. ASHBY: But we can take that up next time, which was kind of the point there.

DR. WILENSKY: The draft rural referral. I'd like to ask that people think about this as one of two options for this recommendation. One is we can require meeting the same wage threshold, or the one that was in the text as an alternative which is that they wages should be at least above average in the state, which strikes me as a somewhat less harsh rule.

MR. KERNS: In the state rural area, if they are a rural hospital.

DR. WILENSKY: In the state rural area, yes. I think I would be more comfortable in making -- at the very least they ought to be above average in order to get this special treatment.

MR. HACKBARTH: How many rural referral centers would lose their status based on using the state average?

MR. KERNS: Twenty-three percent of those reclassified, 23 percent of 177; 40, something like that.

MR. HACKBARTH: And then if it's 106 percent how many would lose?

MR. KERNS: About half, so 85.

DR. WILENSKY:

I feel comfortable saying, if you're not at the average, forget it. That's it. But putting to the same one just strikes me as a higher threshold than we're going to actually get, whereas maybe we can sell this.

MR. KERNS: One small thing to point out is the criteria for reclassification was just reduced from 108 to 106 and they're not even meeting that one.

DR. WILENSKY: Whatever. Let's get them to above average. I don't really disagree in principle. I'd just like to make sure -- because I think we're more likely to stay where we are if we have this --

DR. ROWE: Is above average above the average or above the median?

DR. WILENSKY: I was thinking of it as 100 percent which would make it above the average.

MR. KERNS: What was your question, Jack?

DR. WILENSKY: Was it above the average or above the median? Probably the median is lower.

MR. KERNS: Average, the mean.

DR. WILENSKY: The mean would be higher, I assume. The average should be higher, and it would be in the way up to -- I would like 106 percent. I don't think that's an unreasonable target. That's the wage rate that's now in law. I would like to, at the very minimum, to not have wages that are at the average, and to be able to claim special status strikes me as inappropriate.

DR. ROWE: And the mean would be higher than the median.

DR. WILENSKY: The mean will be higher -- I'm saying that. I assume that --

MR. KERNS: Assume larger hospitals pay more, and it's a reasonable assumption.

DR. WILENSKY: I don't know it, but my guess will be the mean is above the median. So I would prefer to see the recommendation say at least should be the average, require the average for reclassification.

MR. KERNS: The second measure, the compromise measure.

DR. WILENSKY: Right.

MR. ASHBY: So we'll change the wording accordingly and that's what you're going to vote on?

DR. WILENSKY: Why don't we vote on that first, and if you want we can vote on this one second?

All those in favor of requiring that they meet at least the average wage threshold requirement, voting aye?

Voting no?

Not voting?

Is there an interest in having a vote on this higher threshold?

Okay, we'll leave it at this. I actually initially supported the recommendation, this one we're talking about, the sole community hospital. Initially when I read what was in there I supported the notion that was in there of counting the critical access hospital in determining for sole community hospital purposes whether there was another hospital in the area.

1 But as I have thought about it more, I don't find
2 that consistent. That is, when you're a sole community
3 hospital presumably you are acting in a particular position
4 in your community; that you're the only full-service
5 hospital in the area. I think that's a relevant
6 requirement, that you be the only full-service hospital in
7 the area.
8 While I understand the concern that you've raised
9 or that HCFA has raised that with a substantial increase in
10 the number of critical access hospitals popping up, do we
11 now lose the sense of what it means to be a sole community
12 hospital. My comment would be, if that's really a problem
13 we ought to reexamine our definition of a critical access
14 hospital and not reexamine how we define sole community.
15 Sole community is the only full-service hospital in 35
16 miles, or however we define it. I think that's the right
17 distinction.
18 If we're somehow getting non-critical access
19 hospitals into the critical access definition then that's
20 what we ought to go back and reexamine. That's just as I

have thought about it more, this isn't the right place to clamp down. It's what we may be allowing in as critical access hospitals.

MR. ASHBY: As we said before, that's probably an issue we want to monitor is the escalation of what CAH means. Hopefully, the low volume adjustment would make some progress in that regard, because if someone's under the margin that would be helped by this then we may be able --

DR. WILENSKY: Maybe they don't have to become critical access hospitals.

MR. ASHBY: Exactly, we'll have less becoming critical access.

DR. WILENSKY: Right. And I think that would be a better way to fix this problem.

DR. ROWE: If you think about it from the point of view of the beneficiaries rather than the hospitals, how would this recommendation help the beneficiaries? It wouldn't.

MR. KERNS: It would help the trust fund.

DR. ROWE: I mean, it's all about hospitals. It's

not about beneficiaries. It's really not going to help -- the hospitals are what they are. Changing the label isn't going to --

MR. KERNS: It would change the way they're paid.

DR. WILENSKY: But it's about what it does to hospitals. The fact is, from a beneficiary's point of view you are still only assured that there will be a full-service hospital within 35 miles.

DR. ROWE: That's my point.

DR. WILENSKY: That's why I recommend we do not adopt this.

DR. BRAUN: It almost seems as if it ought to be upside down. Critical access hospitals should not be able to become one if they're right close to a sole community hospital.

MR. ASHBY: That is also policy, Bea, they have the same 35-mile standard except that the states can waive the standard.

DR. WILENSKY: Let me go back and say that if we think there's a problem, I believe the problem may be how

1 the critical access hospital is being defined. If at some
2 point we want to say that, let's go back and have that for
3 consideration. Obviously we're not ready to say that today.
4 DR. ROWE: So we'll get rid of this
5 recommendation.
6 DR. WILENSKY: We'll get rid of this
7 recommendation, and I'm open for reconsideration at the next
8 appropriate time on definitions of critical access hospitals
9 if we think that's a problem.
10 MR. KERNS: We did talk about it last month, the
11 same issue, with the rapid increase in critical access and
12 whether --
13 DR. WILENSKY: You told us that but you haven't --
14 and I gather it's because governors can ignore --
15 MR. ASHBY: Yes. Now that we have our road mile
16 figures we can tell you that only 20 percent of the CAHs are
17 actually more than 35 miles from another hospital.
18 DR. WILENSKY: But what are they? It's one thing
19 to say that they're not more than 35 miles. Are these
20 usually like 20 miles? Are we talking about 15 --

MR. KERNS: They're supposed to be 35, but it can be waived.

DR. WAKEFIELD: But we don't know how many it's been waived --

DR. WILENSKY: How many are being waived and what impact is it? We've raised the issue --

MR. KERNS: I would be happy to look into that.

DR. WILENSKY: That's what I'm saying, I think that the issue about whether there is inappropriate designation of the status of critical access hospitals is an issue that we ought to be willing to make a decision. While the issue was raised in our March meeting, informing us about what the real implications are -- again, it's one thing to say they're not meeting the 35-mile, but are we talking about 29.5 miles or 31 miles?

MR. ASHBY: We do have some data on that. Now most of them fall between 20 and the 35. Almost all of them are in that --

DR. WILENSKY: So we're not talking about big clusters of holding centers near sole community hospitals.

MR. ASHBY: No.

DR. WILENSKY: Again, if you want to come back in our next discussion and say, here's now an informed, empirical analysis of what's been going, and we'll also have another year --

MR. ASHBY: Sure, and then we can monitor the progress on the program itself too.

DR. WILENSKY: Exactly. So I think that it may be that we will --

MR. ASHBY: We'll keep it on the agenda.

DR. WILENSKY: -- have something to say about how critical access hospitals are being defined, and what the empirical implications are of what's gone on, but not do it this way.

DR. WAKEFIELD: I do want to make one comment though on CAHs, and that is the way we've got them described in the narrative -- and I'll be happy to provide you with at least my suggestion related to language -- is not exactly on target. It's not quite the characterization that I think is consistent with what's in statute. That is we've got them

sounding almost like MASH units, and in fact they're not, or they don't have to be. They never, to my knowledge, were designated to be something that focused purely on ER and enough inpatient services to stabilize. That's not exactly what you're saying but it could be interpreted that way.

In fact they're limited in terms of inpatient capacity, bed size, and length of stay averages. But there's no statutory language that says, CAHs can only offer this particular service set, for example. So I want to at some point go back, not now, but with the staff and make sure that we've got the accurate characterization consistent with what's in statute and what I think was the intent, which to me this leads you down a slightly different road.

I'd also say in terms of the governors' designations, I think we really do need to know what numbers we're talking about there because otherwise this could be a very small issue or it could be a very significant one. It keeps coming back without data.

DR. BRAUN: I do think we want to know how often do we have two hospitals in one town and one of them would

1 have to close except now they've found the CAH designation
2 and they can stay open. I don't think we want that to
3 happen.
4 DR. WILENSKY: That's why it really does strike me
5 that the questions we're raising are legitimate questions
6 that have to do with the status of critical access hospitals
7 and we ought to have some analysis done, and we can make
8 recommendations that we think are appropriate when we have
9 that analysis.
10 DR. WAKEFIELD: Should we vote on this?
11 DR. WILENSKY: My sense was that I saw the heads
12 nod so I'm inclined to --
13 DR. WAKEFIELD: I wasn't asking for one.
14 DR. WILENSKY:
15 Do we have one more recommendation on this?
16 MR. ASHBY: No, that's it for the recommendations
17 on PPS hospitals, but we now have psych facilities.
18 DR. KAPLAN: Last month we talked about the reason
19 for studying PPS-exempt psychiatric facilities. The BBA
20 established a target cap for these facilities based on the

75th percentile of all facilities targets. For each discharge, psychiatric facilities are paid at the lower of their own costs, their own target, or the target cap. The aggregate margin decreased 5 percent to minus 2.3 percent in the first year the cap was in effect. Beneficiary access may be negatively affected by the target cap.

One target cap treats all psychiatric facilities as if they have similar case mix and treatment patterns. However, we found that government-owned hospitals are different. They admit a higher proportion of disabled beneficiaries compared to aged, and a much higher proportion of patients committed involuntarily. Their length of stay is about double that of either other freestanding hospitals or hospital-based units, and more than half of the government-owned hospitals have a cost per case over the target cap in both urban and rural areas.

Rural hospital-based units don't look very different from other freestanding or urban units, but 30 percent of them have cost per case over the target cap. We'll look a little closer at rural units in a moment.

First, on this slide we see average cost per case by hospital type, and the average for facilities with cost per case over the cap. In each group, facilities with cost per case over the cap are way over. As you can see, government hospitals have a much higher average cost per case, and hospitals over the cap have a cost per case about twice the size of the cap. This figure also shows that in each group rural facilities have higher cost per case than their urban counterparts.

As I said before, 30 percent of rural hospital-based units have cost per case greater than the cap. When we examined the units more closely using the UICs, we see that except for areas non-adjacent to metro with a city of 10,000 or more, as facilities become more rural the average cost per case increases.

However, length of stay doesn't increase in the same way as cost per case. For example, in the two areas with the seven, 11-day average length of stay, the average costs are 30 percent higher in the more rural area.

We were unable to use the same weights to derive a

case-mix index for government hospitals because they are so different. However, preliminary case-mix indices for the other two facility types show that rural facilities have a higher case mix than urban facilities of the same type. Urban other freestanding hospitals have a higher case mix than your urban units, but the case mix is the same for rural other freestanding hospitals and units. This information was not included in your mailing materials because I didn't have case-mix indices then.

One target cap for all facilities does not appear to work well for psychiatric facilities. The evidence shows substantial differences in these facilities although we may not know exactly why all the differences exist. The prospective payment system for inpatient psychiatric case is mandated to begin on October 1st, 2002. Not everyone thinks that the PPS will happen on time, so one could think if the recommendation on the screen as the fallback just in case it doesn't.

There also was some discussion in the mailing of rural hospitals closing psychiatric units to apply for

critical access hospital status. We didn't feel it was appropriate to make a recommendation about this issue at this time.

So we'd like at this time for you to discuss the draft recommendation, which is that the Congress should revise the target cap for inpatient psychiatric facilities in a way that better addresses differences among them.

DR. WILENSKY: Any comment?

DR. BRAUN: No particular problem with the recommendation. I just would like to bring up that we might put in the text, one of the things that raises costs in the rural hospitals particularly are the conditions of participation that require physicians for seclusion and restraint, because in large hospitals where they have residents that isn't a problem, but it definitely adds to the costs a lot in rural hospitals.

DR. WILENSKY: Ready to vote?

All in favor? All voting yes?

All voting no?

All not voting?

Thank you.

DR. KAPLAN: Thank you.

DR. WILENSKY: Thank you, that was a good and appropriately detailed discussion on the inpatient hospital.

Home health care, Sharon and Sally?

I apologize if there are people who are waiting for public comment, but we're going to go through the end of this since we're already about 45 minutes behind.

MS. BEE: In this session this afternoon we will conclude a discussion that we began last month on whether or not rural home health should be exempt from the home health prospective payment system. Last month we discussed the components of the new PPS, information from the previous cost-based payment system, and additional data needs. Today I'll quickly review our analysis and present two recommendations for your consideration.

The concept behind all of our findings is not whether or not the PPS is doing well, but whether or not it will work differently in rural areas. Our first finding is that the payment unit and eligibility for multiple episodes

1 together should be able to accommodate practice patterns in
2 rural areas. The 60-day episode should be long enough to
3 allow agencies to manage care within an episode and conform
4 to the majority of length of stay and the schedule for care
5 planning. Potentially longer lengths of stay in rural areas
6 should be accommodated by allowing multiple episodes, so
7 long as the beneficiary remains eligible for the benefit.
8 Next we find that the base rate plus the 10
9 percent temporary increase provided in BIPA should capture
10 the costs of care incurred by an efficient provider equally
11 well in urban and rural areas. Two factors could
12 differentiate the cost faced by urban and rural home health
13 providers and might not be adequately accounted for in the
14 payment formula, and those are travel and volume. The cost
15 of traveling to serve a sparse or remote population may
16 increase the cost faced by rural providers.
17 Rural providers may also be at a cost disadvantage
18 because their low volume may not permit them to spread fixed
19 costs over a large number of episodes. As we noted at the
20 last meeting, there is no data at this time from the PPS to

measure and assess the effects of travel, low volume, or other costs that may cause an efficient rural provider to have higher costs than an urban one.

Next we find that the case-mix adjustment should fix urban and rural beneficiaries equally well. Historically, urban and rural home health users have been clinically similar. Rural users have somewhat more chronic conditions, which is consistent with somewhat longer lengths of stay. And rural users might use therapy differently, but in the past those who have gotten some therapy care usually get the same amount as urban beneficiaries.

Now the use of therapy in home health has been changing recently, and patterns of therapy use are likely to change again under the new incentives of the PPS. As we noted at the last meeting, data that will come from the PPS will allow us to determine whether similar urban and rural beneficiaries receive different care. Based on historic data and the structure of the case mix, we find at this time that it should capture the clinical and functional factors that shape case mix equally well for urban and rural

1 beneficiaries.

2 Finally, we find no evidence of access problems in

3 rural areas due to agency closures. The count of Medicare-

4 certified home health agencies doesn't include branches,

5 which GAO found provides a great deal of service in many

6 rural counties. The closures that were reflected in the

7 count of Medicare-certified home health agencies were

8 concentrated in urban areas and not rural areas.

9 Rural providers were not the dominant source of

10 care in counties adjacent to metro, which is where half of

11 all rural beneficiaries live. Finally, there is still a

12 higher ratio of home health agencies to beneficiaries in

13 rural areas than there are in urban areas.

14 Given these findings, there is no component of the

15 PPS that should be more or less adequate for rural home

16 health. Continuing the current payment system with the 10

17 percent increase provided in BIPA to temporarily offset any

18 potential problems in rural areas will allow us to assess

19 the impact of PPS and test any changes that may be

20 appropriate.

I'd like to note that we've used the term services in this recommendation instead of agencies because differences in urban and rural home health payments are determined by the location of the beneficiary rather than by the location of the agency. So at this time we propose to recommend that the Congress should not exempt rural home health services from the prospective payment system.

DR. ROSS: Maybe you'll want to follow the tradition of going all the way through and then coming back.

MS. BEE: This brings us to the second issue, how can data that would allow us to measure the impacts of the PPS be generated? In conducting the analysis for this report we were told not to rely upon cost reports, especially for the data on travel costs that we wanted, because the data is inconsistent from agency to agency. The form of the cost report does not always follow the function of producing the service and guidance to reconcile form and function is unclear.

Cost to provide escorts, beepers or cell phones to employees who see clients in dangerous neighborhoods seemed

1 to fall prey especially to this inconsistency. Also travel
2 costs which could be counted as direct patient care expense,
3 administrative cost, or a not-allowed cost at all is prey to
4 these inconsistencies.
5 Problems with the data that we see now are likely
6 to be exacerbated under the prospective payment system as
7 cost reports will not be linked to the agency's
8 reimbursement. What incentive is there for a provider to
9 commit their time and energy to really solid cost reporting
10 if success does not result in better reimbursement and
11 failure does not result in significant penalties?
12 To address problems with the data, we propose to
13 recommend that the Secretary should improve the quality of
14 data on home health cost reports by substantially increasing
15 the audit rate for cost reports, and clarifying allowable
16 costs and the documentation required. New resources will be
17 required to increase the audit rate. Developing new and
18 meaningful penalties for inaccurate data would also be
19 needed. It may be difficult to generate sufficient
20 incentive without burdening providers and making Medicare's

relation with them an unacceptably punitive one.

In addition to efforts to improve all cost reports, HCFA could create a pool of providers, perhaps the group whose cost reports were used to make the PPS. This group of about 500 providers was thought to have especially good report and with some weights it comprised a nationally representative sample of agencies. New resources would be needed to support continuing comprehensive edits of these reports, and there might be a need for some compensation to participate in the group. However, this pool could provide very good cost data.

In the long run, we will need good data from the implemented PPS to assess whether rural providers will face higher cost per episode than the national mean due to costs beyond their control, and whether similar urban and rural home health users are receiving different services under the PPS. Evaluating these two questions will be essential to understanding the PPS and its impact on rural home health.

MR. DeBUSK: Getting this cost data, we're not even into this prospective payment system -- I mean, we're

just going into it, getting into it, and we go out here and we're going to start really hammering down on trying to get, what does it cost you to provide this service. Then I go back and I look at the OASIS and the HHRGs, seems like we've come right back to the same place every time with burden the whole system with more data, more collection.

A lot of this has got to be counterproductive in our approach on how we do this. You look at the whole OASIS system, you got 80 categories and the whole darn thing could be done with 23. And it takes two-and-a-half hours to fill these things out.

I just guess I object overall to the structure of how we approach this.

MS. BEE: We're not suggesting that there be a new cost report or that there be new data collected. The recommendation is that we audit what we get to see if we can improve the quality of it. And at the same time, if we can clarify what we're asking for, and especially what documentation we're asking for, that might actually ease compliance and improve the quality of data. So we hope that

1 we have sort of a stick and something of a carrot.

2 MS. RAPHAEL: I support your first recommendation.

3 I thought you did a very good job and you made a persuasive

4 case in the text.

5 The second recommendation I find a little more

6 troubling because in your text you talk about the fact that

7 increasing the audit rate can help to improve the accuracy.

8 But then you go on to talk about the fact that right now

9 there aren't really good incentives to produce accurate cost

10 reports and you think that it may be difficult to generate

11 sufficient incentives without burdening providers, and you

12 think this would burden providers. So I'm trying to

13 reconcile this.

14 Then you come up with another proposition that

15 maybe we ought to use those who were involved in the

16 national demonstration, who really are a good, nationally

17 representative sample, and keep working on their cost

18 reports and trying to understand it.

19 So that I would wonder why we would want to burden

20 every provider when we don't have the incentives right now -

- and every cost report is reconciled. There is a reconciliation that you go through with your fiscal intermediary. Rather than take this representative group as the group that we've put under the microscope, to really better understand transportation costs and other costs that legitimately need to be paid for, perhaps in a different way.

DR. WAKEFIELD: I came in a couple of minutes late to this so I'm sure I probably missed some comments that you made, so perhaps you'll correct me. But when I read through this chapter and this particular, the first recommendation, my view about this was, I'd frankly rather replace this recommendation and ask the Congress to look at some special payments for -- to assess the need for and develop some special payment methods for low volume, sole community home health agencies.

I think that it's the same notion of trying to determine what's going on with low volume that applies to home health agencies that does to hospitals, as we discussed them in terms of inpatient data earlier. We don't have

enough data on that point.

But I think this recommendation, one, strikes me as a bit draconian because it brings everybody along. I'm not comfortable that, as I said, small, low volume, sole community home health agencies are adequately protected right now in terms of payment policy. So I have a concern about that, about the way this reads, and I frankly would prefer to see it replaced.

DR. WILENSKY: The way which reads?

DR. WAKEFIELD: We're talking about recommendation one.

MR. DeBUSK: I think we've got another problem. I think part of these home health agencies need to go away in these rural areas. I believe propping them up is nothing but a problem. There's too many of them. There's still too many of them. Some of them occasionally will have some hospital relationship there, but then you've got all these that sprung up from this group of doctors refer their patients here, and this here. I mean, there's just so many of those it's unreal.

DR. WAKEFIELD: Can I respond for just a second? My concern is monitoring the impact of the home health agency payment on rural agencies. I take your point about over-supply. I don't think we want to do anything that encourages that. But it's my understanding that HCFA had very little data about rural agencies specifically. They were looking at a very small number when they developed their home health PPS.

In their per-episode demonstration study, about 13 of the 80 agencies that were studied were in rural areas, and only seven of those 80, it is my understanding, were hospital-based. That's according to Mathematica's work. The math of those numbers suggest that as few as one or two of those study agencies might have been rural hospital-based agencies. In 1996, two-thirds of rural home health agencies were hospital based.

So I'm concerned about the data that we're spinning off of in terms of the payment methodology that was developed and whether or not it adequately -- I'm not suggesting all rural hospitals, I'm not defending all rural

hospitals. I'm saying, do we need to be concerned about a subset of those rural -- excuse me, all rural home health agencies. Do we need to be concerned about a subset?

I would suggest we probably do. That the data that the PPS system was built on was pretty small. It was awfully thin.

DR. WILENSKY: I understand the concerns about the data that the PPS was based on, but is that an argument for saying you should just exempt rural home health from PPS?

DR. WAKEFIELD: No, I was saying, I don't think we should put all of rural home health into the same basket. I was suggesting that we take a look at a recommendation that would encourage the consideration of developing a payment that's based on sole community, low volume, home health agencies.

This doesn't provide that consideration. This moves everybody over into one category. I'm saying, could we get consideration for low volume, keeping that theme consistent as we applied it with inpatient hospitals as well. Asking them to look at it. Obviously we don't have

the data on which to base a payment methodology.

DR. ROSS: It's also not exactly parallel because the concept of low volume dealing with an agency versus dealing with a hospital --

DR. WILENSKY: With a high capital structure. The reason that for hospitals low volume becomes such a big issue is hospitals are characterized as high fixed cost, low variable cost institutions. When you have a low volume that really hurts you.

DR. WAKEFIELD: That's a problem.

DR. WILENSKY: My sense is one of the reasons that people have said we shouldn't get too hung up on the number of agencies per se is that agency, expanding service within a given agency, popping up with a new agency when you have very low capital intensive groups like home health, is a very squishy concept. So the number of agencies per se is not a very useful measure because of the fact you don't have the big capital entry barrier that you have with hospitals.

Now I don't have any problem with getting more information on a volume-cost relationship, but I don't think

exempting before we have that information -- I would support the notion of collecting appropriate information so we can see whether or not there may be a differential cost relationship according to volume or sole community. But I would say, go get the data, as opposed to exempting first and then getting the data.

MS. BEE: Is your sense that it wasn't punched enough in the text, or that this recommendation -- as I was trying to craft our support for this recommendation, what I tried to do as well as I could was to say, in the absence of data but from a reasonable theoretical standpoint, we think that the basis is adequate unless the effect of low volume or the effect of travel makes an efficient rural provider's cost higher than urban. And tried to hit a couple of times in the text that those are two costs that we need to look at as PPS is implemented.

DR. WAKEFIELD: What I'd say is I'm looking for, and think that it's important to have some consistency across different agencies, different provider types in rural areas. To the extent that we think that there's something

1 important about low volume potentially related to high unit
2 costs, not just for inpatient hospitals but also for home
3 health care, then could we also make that a recommendation?
4 To say, could we look at that too? We found it to be pretty
5 important for a subset, just a subset of rural hospitals.
6 As I said, I want to be very clear, I'm not saying
7 some sort of an adjustment that captures all rural, all home
8 health agencies in all rural circumstances. I'm again
9 trying to think about targeting policy for that provider
10 group that might be out on the front lines, fairly isolated,
11 sole community, that if they weren't there, would put those
12 beneficiaries at risk.
13 So how do we do that? The first thing I think we
14 have to have is some data, if there are -- there needs to be
15 some pursuit of data that would, at the starting point, show
16 a relationship, if there is one, between high unit cost and
17 low volume with home health agencies. The same principle as
18 we've applied with inpatient hospitals.
19 DR. REISCHAUER: But I think what Gail was trying
20 to say is there is no strong theoretical reason to expect

that to be the case. There's an issue here that you don't want to make a mistake, and I think that's what you're focusing on. But in the absence of some theoretical reason for why we would expect this to turn out badly, I think the furthest we really should go is to tell the Secretary to monitor carefully the situation in these types of situations because should these agencies face problems, there is no fallback, or the fallback is a long drive away.

DR. WILENSKY: We could modify the recommendation too by including the collection of some of the data that Mary was alluding to. But again, I think there really isn't a reason to expect going in that this should be a problem. But we certainly should monitor it, we should collect the data, see whether or not there appears to be higher unit costs for certain kinds of --

DR. WAKEFIELD: Could then we incorporate some language like that, and consistent with Bob's comment, to ask the Secretary to, as soon as possible, monitor the impact of the home health agency prospective payment on rural agencies?

MS. RAPHAEL: But I think the key variable -- I don't think volume is the issue here. I thin there is an issue about transportation costs, and not having good information on transportation costs. Maybe the second recommendation ought to highlight the need to get better information on what the added costs are of transportation. I think it pertains to inner-city communities as well as to rural communities.

DR. WAKEFIELD: I agree with that too, and I think a recommendation there is, the Secretary should conduct a study to determine if supplemental payments for travel costs are needed in some home health. I would say rural home health agencies. You're putting urban in the mix and I understand that too.

MS. RAPHAEL: I am because I think it's a big issue.

MR. DeBUSK: We got 10 percent now though, right?

MS. RAPHAEL: We have 10 percent till 2003.

DR. WILENSKY: Sharon, you may want to rework recommendation two and come back and let us see the language

tomorrow morning to see whether we've alleviated that concern.

Let's vote on recommendation one and we'll postpone recommendation two until we see the rewording tomorrow morning.

All those in favor?

All those voting no?

All those not voting?

Craig?

MR. LISK: Good afternoon. In this late hour, we're going to go back again to our mandated report on Medicare payments for nursing and allied health education which is due the end of May. What I want to first do is just briefly review again the congressional mandate. Congress asked the Commission to really focus on two questions.

The questions in the report were, is there a basis for treating different classes of non-physician health care professionals differently in Medicare's payment policies for GME? And what is Medicare's role in supporting clinical

training? Congress was interested in information on the extent of Medicare's support for financing clinical training for non-physician health professionals.

There are differences in the treatment of clinical training costs for hospital-based programs versus programs sponsored by academic institutions which both may have substantial clinical training in hospital and inpatient, outpatient settings. The program only supports programs that are hospital based and hospital operated.

Also in terms of the question of the different types of health professions is that the types of health professions supported through the pass-through is another issue that I think the Congress is wondering, in terms of psychologists, for instance, and physician assistant programs are generally not supported through the program.

Briefly in terms of reviewing Medicare payment policies for nursing and allied health education. Clinical training costs have been considered allowable costs for facilities since the beginning of the Medicare program. When PPS for hospitals was implemented, clinical training

1 and classroom costs for hospital based training programs
2 were carved out and paid as a pass-through. But clinical
3 training costs for non-provider operated programs were
4 included in the base PPS payment rates, which is consistent
5 with basically the Commission's views as they've expressed
6 about graduate medical education payments for residents.
7 With regard to billing on Part B services, only
8 licensed personnel may be reimbursed for Part B professional
9 services provided in the course of training. Services
10 provided by trainees in terms of Part B services are not
11 reimbursable.
12 There are some basic requirements that HCFA has
13 that a provider must meet in order to meet the hospital
14 provider operated program requirements. It must directly
15 incur the training cost, directly control the program
16 curriculum, control the administration of the program, which
17 includes things like collecting tuition, employ the teaching
18 staff, and provide and control both classroom and clinical
19 training. The program must also be recognized by state
20 licensing organizations or a national approving body. So

1 those are the basic requirements for a program to meet and
2 be eligible -- a hospital in order to be able to be
3 reimbursed for the direct costs.
4 Medicare's payments for nursing and allied health,
5 this slide provides some basic information on that.
6 Payments total roughly about $250 million. Two-thirds of
7 these payments are for nursing education programs, which
8 roughly go to a little fewer than 300 hospitals. One-third
9 of the payments are for allied health profession training
10 programs which go to about 550 hospitals.
11 Now interestingly, roughly two-thirds of these
12 hospitals also receive payments for residents through the
13 current direct and indirect payment adjustments. About half
14 of the major teaching hospitals receiving nursing and allied
15 health payments, and about two-fifths of the other teaching
16 hospitals, although other teaching hospitals receive the
17 largest share of these dollars.
18 Now this next slide reviews the basic Commission
19 views about education and training costs which we discuss in
20 the report. The trainees bear the cost of general training

by accepting lower wages and paying tuition, and that Medicare's education payment should be treated as patient care cost, and that Medicare should recognize the higher cost of teaching settings if the added costs are commensurate with the added value of the patient care services.

We are uncertain though whether providers who train nurses and other allied health professionals have higher costs. We did take a look at that.

The next slide outlines some of the questions to consider that are discussed in the report. I'm going to go to the first one, then the next slide, and we're going to skip back to this slide. Are hospitals that provide non-physician health profession training more expensive? As you recall, you had suggested that we take a look at what the relationship was by adding in these costs and seeing whether these hospitals have higher costs.

So we can ask the question, are hospitals that provide training more expensive? What we found is per case cost for hospitals receiving pass-through payments are 1.8

percent higher. This estimate though does not reflect differences in the level of involvement in training and cost per case. The estimate may be too low though because it only identifies hospitals receiving pass-through payments. So there's many hospitals that are involved in clinical training that were not counting, identifying here, so that may make our estimates actually too low if those hospitals in fact have higher costs.

The other aspect is the estimate could be too high because these hospitals, in terms of what they are allowed to claim includes classroom-related cost that the other hospitals who may participate in clinical training do not incur. So if the net tuition that's charged doesn't offset those costs that may be an explanation for the higher cost.

But the basic bottom line is we really don't know whether these providers have higher cost. We would need to collect more data on that.

So if we go back to the other questions to consider, we also have the question of, does training contribute to enhanced patient care, which is one of the

fundamental components also of the Commission's previous recommendation. We can make some assumption, as we made for hospital residents that the higher cost we observed, if they exist, may be related to enhanced patient care. But again, we really don't know this for certain and more analysis would need to be made to identify the hospitals and the intensity of training that takes place or something of that sort.

The third question that we discuss is, are there issues that make non-physician training different from residency training? There are a couple of issues that make this nursing and residency training different. First, training for these programs is pursued before the degree is granted, whereas residency training is pursued post-M.D. degree, which you may then consider these things a little bit different for these groups. Residents also receive a stipend throughout their training, whereas most of these trainees in these other allied health professions and nursing do pay some form of tuition.

The paper discusses some of the issues about this

tuition where there are certain circumstances where the student doesn't necessarily bear the full cost of the tuition because of subsidies that schools have and the fact that there isn't necessarily a charging back from the hospitals and other clinical training sites back to the schools.

Now again, there may be no net additional cost. That may be why the hospitals are doing that. But again, we're not clear whether those institutions actually have higher costs.

The fourth issue on this slide --

DR. ROWE: Can I ask a question about that, Craig? Did you consider, do you think it has an impact that the intensity of the training is different? I don't know in these non-physician training programs how frequently people are on all night in addition to all day, and the average resident is in the hospital over 80 hours a week I think.

MR. LISK: That may be contributing --

DR. ROWE: So if you look at the number of residents versus the number of nurses or number of

occupational therapists, that's one way to compare it. But if you look at the number of hours of training that is involved, that might yield some different kind of analysis.

MR. LISK: I totally agree in terms of when you're talking about -- and we'll get to recommendation on collecting data -- is that you would need information, I believe, on the amount of training and the amount of activity that is taking place in a facility. That makes it a very difficult data-gathering exercise though I believe.

The fourth issue in terms of the impending shortage for nursing and allied health professionals, this may or may not make a difference. In general though, the Commission has previously stated that it is not Medicare's role to get into workforce policy, and we do have a proposed recommendation for you to consider reiterating your recommendation you made back in August.

On question five, can hospitals' involvement in training be quantified? As we discuss, we don't really have the data to do that at this point. We again have a recommendation for you to consider for collecting such data,

for the Secretary to collect such data and examine that issue.

Then in terms of the issue of how payments can be adjusted, ultimately the Commission may want to be consistent with its previous recommendations, and we'll also get to that as another potential recommendation for you to make.

Then the final question in terms of what Congress asked, should the various health professions be treated differently in these programs? As we previously stated, hospitals almost never receive pass-through payments for certain health professions. In one issue, HCFA has revised its regulations on that. They have not gone into final effect because of the delays that were made, because this is one of the regulations that was delayed some with the Bush Administration going in, but I believe it will go into effect without any change.

So HCFA eliminated this list of programs, so that's no longer really an issue in terms of hospitals meeting -- if a program meets the criteria that HCFA has,

1 the hospital will be able to receive reimbursement for those
2 programs if they meet those criteria.
3 The general other issue here though is the
4 programs not operated by providers, hospitals will not
5 receive pass-through payments for them. When we get down to
6 a final issue for you to consider in terms of short run
7 recommendations we'll have you consider that as well.
8 So I wanted to provide also some brief review of
9 the Bureau of Health Professions programs that I had
10 mentioned last time but wanted to provide you with some
11 information in terms of the amount of funding for these.
12 The current authorization for Title VII, which does deal
13 with training primarily for physicians, does have
14 subcomponents that deal with allied health professions and
15 physician assistants training. Total funding appropriated
16 in fiscal year 2001 for those programs is about $8 million
17 each. These programs are meant for cost associated with
18 expanding or establishing programs to increase the number of
19 individuals trained in various allied health professions and
20 in physician assistant programs.

Title VIII programs provide funds to support nursing education. Most of these funds go to support nursing education to train R.N. to master's and post-master's certificate programs, to train nurse practitioners, and clinical nurse specialists, and others of that sort, and nurse educators. So that's the vast majority of the nursing money.

So basically nurse education program offers grants to strengthen programs that provide nurse education. The diversity program provides grants to help students from disadvantaged backgrounds. HRSA is authorized to provide scholarships for this program but they lack the funds to do so, they have not.

The loan repayment program provides 85 percent of loan repayment for entry level RNs and advanced practice nurses who agree to work at least two years in health service facilities having critical shortage of nurses, and the Nurse Health Service Corps provides nurse practitioners and certified nurse midwives, education support in exchange for service recognition.

Now in terms of seeing these dollars, as I said, these are much smaller compared to what Medicare currently has in payments for direct -- as its pass-through payments. But the other thing in terms of recognizing scale is, at least in the most recent number I was able to find for the number of nurse graduates, R.N. graduates was about 90,000 back in '95. I think that has shrunk down maybe closer to the 80,000 range currently. So if you think about the number of nurse trainees and the dollars there. Allied health professions though are even larger than the nursing field as well.

So with that I'd like to go to your discussion in terms of the recommendations and your approval. So there are three draft recommendations and then a proposal for whether you want to consider other recommendations.

DR. WILENSKY: Before we get to the recommendations, are there any comments that people would like to make about the information we have?

DR. NEWHOUSE: First a question, Craig. Of this 1.8 percent difference, do you know how much of that is

accounted for by the GME payment of $300 million?

MR. LISK: Basically we threw in the $300 million, so that we get the 1.8 percent effect when you throw in the GME payment.

DR. NEWHOUSE: I know you did that. But suppose you didn't --

MR. LISK: If we don't throw the direct GME payment in we get no effect.

DR. NEWHOUSE: I'm only talking about nurse and allied health part of the GME.

MR. LISK: Correct, that's what I'm talking about.

DR. NEWHOUSE: You got no effect.

MR. LISK: So when you don't throw those monies in, you don't get an effect. When you throw those monies you, you get a 1.8 percent effect.

DR. NEWHOUSE: So I think there's a difference that I'd like to bring out between the how we handled the resident issue and this one, which is -- there are a couple differences I want to bring out. One is, the original resident adjustment was estimated off the old cost

reimbursement system. That is to say, in the world of ancient history, teaching hospitals were more expensive than non-teaching hospitals when all were under cost reimbursement.

Now if I come to this issue and I say, the students are bearing the cost of their training, but now I'm going to give the hospitals that train them $300 million, I wouldn't expect them to stuff it in their pillow. I'd expect them to spend it on something. So I would expect that that would show up in higher costs. However, at one level all I'm doing is advantaging them relative to the hospitals that didn't have these training programs, and I'm not sure I should want to do that.

The difference being that if I'd gone back to the situation before I gave them the $300 million, then the costs presumably would have been the same from what you just told me. Whereas that wasn't the case with teaching hospitals defined as we usually define them with residents to bed. So I'm not sure there's --

The second issue is, as you've said, these are

1 people that are being trained that aren't licensed. It's
2 therefore not clear to me that I'm getting any kind of
3 different product in the sense that I think I'm getting it
4 from teaching hospitals. That is, the fact that residents
5 are around all hours of the day and night and are actually
6 doing patient care to me suggests that there is a different
7 product in a teaching hospital. The fact that here are
8 people, pre-licensed, being trained, doesn't convince me
9 that there's a difference in the product, or if there is,
10 it's something I should want to pay for.
11 My recommendation issue is that while I -- that
12 draft recommendation language isn't up there but I would
13 have actually included, if the Congress -- when we talk
14 about supporting number, specialty mix, and geographic
15 distribution through targeted programs I would have
16 inserted, supported from general revenues rather than
17 through Medicare payment policy. I think that's implied but
18 I think we ought to make it explicit.
19 MR. HACKBARTH: Can I just ask a question of Joe?
20 It sounds to me like that reasoning leads you to the

conclusion that we ought to take out the existing dollars and just save the money, or are you saying we ought to fold them back into base rates without any adjustment?

DR. NEWHOUSE: In terms of these options at the end of the line here that were said to be mutually exclusive in our packet, I would have said we could either return it to the base rates or we could use it, or an equivalent amount for general revenues to BHP. The issue goes back, it's such a minor amount we'll never know, but at this point these are kind of costs in the system. So putting it in the base amount seems to me to be a reasonable thing to do even if they wouldn't have been in the base amount if we'd never had this adjustment in the first place, arguably.

DR. WILENSKY: Also consistent with what our discussion was in talking about graduate medical education where we wanted to make clear we weren't making a recommendation as a cost-saving strategy, and therefore basically did not make use of empirical estimates to justify where to put the amount, but rather regard it as money that ought to stay within the system but be redistributed. It

seems to me we're being consistent either with putting it in the base or giving it to the Bureau of Health Manpower, but not using it as savings.

DR. WAKEFIELD: Just a couple of comments. First of all, the first draft recommendation on Medicare's role is, while I've articulated on other occasions some of the difficulties that I have with some of this language, nevertheless, I believe that that first draft recommendation is, as it reads in text -- not with any other changes, but as it reads in text is consistent with language that we've used previously related to GME, regardless of what health care provider group it's supplied to.

MR. LISK: Correct.

DR. WAKEFIELD: So it seems to me that language is consistent as it reads up there.

MR. LISK: Yes.

DR. WAKEFIELD: I'll just say for the record that I haven't been dissuaded from the notion that there is a need for data collection. I'm sure somebody will talk to me over dinner or another time and explain to me further why

there isn't a need for data collection. But the point I'm making is, I support the second draft recommendation that data should be collected to determine whether or not providers participating in training have higher patient costs in part because, unless I'm misunderstanding your comment on the previous slide that says, some of our estimates may be too low because we're only identifying hospitals that receive pass-through payments.

MR. LISK: That's correct.

DR. WAKEFIELD: And we've got other educational institutions that are placing their trainees in hospitals and those training costs are landing somewhere.

MR. LISK: We're presuming that the trainee is bearing those costs, but those facilities may still have higher patient care cost and there may be extra value that we are getting from that. So we don't know the answer to that question though.

DR. WAKEFIELD: Which is why I would support the second recommendation as it currently --

DR. NEWHOUSE: What data would allow us to answer

that question, the extra value question?

MR. LISK: The extra value really is a judgment call in many ways.

DR. NEWHOUSE: I agree with that.

MR. LISK: How we wrote it in the text was making a consistent assumption with residency training and other types of training may add value, if we see those higher costs and take the assumption that the residents -- and the trainees are bearing those higher costs. If we see higher cost related to this, then that may be added value. So that's the assumption that we made in terms of how we wrote the draft.

DR. WILENSKY: But that strikes me again, with reference to what Joe said, that the presumption of increased value that was associated with having residents within a hospital was based on the fact that having people available to provide services in the middle of the night, or having the availability of state-of-the-art equipment associated with the training of graduate physicians was why we thought there was some kind of enhanced value. One of

the things when we had our discussion about paying for training, that it's not just whether there's higher cost, but being able to rationalize why we think there's enhanced value.

I think we've explicitly at least had the discussion getting ready for our August 1999 report, we don't want to be in the position of saying that we think that there should be financing of higher cost because they're higher cost. It has to be that there are enhanced benefits that are associated with it. I think that was the point that Joe was making, is that when you're talking about undergraduate trainees --

DR. WAKEFIELD: Right, but if I could just jump back in and finish this thought and then I'll be finished. I remember though, at least the way I remember some of the earlier discussions that we had when I first joined the Commission about the notion of enhanced patient care applied to GME, it was a notion in process. It was being developed over the first couple of meetings that I was involved with.

When we were first talking about it, I think we

1 were talking about issues like being able to quantify
2 improved quality of care, or something like that. The term
3 quality was used pretty frequently. And I remember the
4 asking the question, then supposing that, then probably
5 there must be some research studies that exist someplace
6 that show that quality is different in tertiary care
7 facilities than it is in community hospitals, for example,
8 et cetera, and that's generalizable enough that it justifies
9 enhanced patient care. I was coming in new to this and so
10 querying a fair amount along those lines.
11 Then I think the point we got to, no, that's --
12 the point I got to. Let me speak for myself. I couldn't
13 get a sense that that was easy to quantify; that is, higher
14 quality, so we would talk about it in terms of a different
15 product.
16 DR. WILENSKY: There is some data that shows if
17 you look at best practices that academic health centers have
18 higher rates of best practices. Now what was interesting is
19 that it was like 34 versus 48. I mean, more distressing as
20 I recall is that the best practice places were still less

1 than, sort of a 50/50 shot of getting it right. But
2 nonetheless, higher than the community hospitals.
3 It's very difficult to produce good quantified
4 information supporting the enhanced value, but there is
5 information suggesting higher quality.
6 DR. WAKEFIELD: Then I take your point, Gail, and
7 I'd say that obviously that information exists and it
8 informed people's thinking. And it was significant enough
9 to base a payment recommendation, a revised payment
10 methodology on the data that we were looking at then
11 apparently. That that was substantial enough to suggest
12 that that could happen.
13 The point I'm making is, that was sort of an
14 evolutionary process about how do we apply these new
15 concepts to GME? I'd say this too is an evolutionary
16 process about how we apply these concepts to something other
17 than medical residency training. I think we committed in
18 our report to say, when you can you demonstrate -- so a
19 reason to collect I suppose -- when you can demonstrate that
20 there's enhanced patient care and higher cost, then payment

methodology ought to follow that track.

I'd say, there are things that happen differently when you've got clinical nursing faculty in an environment. We don't talk about night shifts with nursing students, et cetera, but I don't even recall that much of it, those things being the reason why we're reimbursing teaching facilities. But there are numbers of nursing education programs that require their students, for example, in hospitals to engage in quality improvement projects in those facilities.

So all I'm saying is I don't think that there's enough information to dismiss this out of hand, and that there's probably a reason to collect data to see whether or not there's a difference.

DR. WILENSKY: But there should be more than data just on cost.

DR. WAKEFIELD: Yes, I agree. Absolutely I agree with you.

DR. NEWHOUSE: This recommendation is framed as just numbers of people being trained.

DR. LOOP: I have a question about folding the education payments into the base rates. Right now I believe that the financial support is only to the hospital that have the training programs. So I guess you're talking about $250 million here. So what would happen if you do that? I think we're in the middle of a nursing shortage. Are there some unintended consequences? We've got a shrinking number of nurse applicants and a shrinking number of education programs. If you fold this into the base rates does that cause programs to have less incentive to train?

DR. WILENSKY: It's why, I think, one of the other recommendations has been to have this money available to the Bureau of Health Manpower specifically for encouraging individuals going into nursing. One of the questions -- part of it you can fold it into the base. Part of it is that you can try to target it more directly to what you think might actually support alleviating a nursing shortage, and the question of whether it has to do with training sites is a real question.

DR. LOOP: I think we should be fairly clear on

this because one of the premises of this chapter is not to intentionally distort the supply of health professionals. We could be indirectly doing that.

DR. WAKEFIELD: To the extent that you leave it to the discretion of Congress -- and I'm sure there's nothing wrong with that -- but there were plenty of groups that were fairly concerned when there was a discussion of moving residency training dollars over to the discretionary account and out of GME. I would just suggest that the same concerns will exist. That while we can recommend here that $235 or $250 million ought to be appropriated; maybe, maybe not, as was the case with residency training; maybe, maybe not.

DR. NEWHOUSE: Yes, but the difference is that there was compelling evidence, for me at least, that even before we instituted the GME payments that patient care costs were higher at teaching hospitals. And therefore we could legitimately, at least I could legitimately classify those higher costs as patient care costs.

Here it doesn't -- first of all, 1.8 is tiny compared to the difference between teaching hospitals and

1 non-teaching hospitals where we're talking about 50 percent
2 or so kinds of differences in cost. But secondly, it's not
3 clear that we would have any difference in cost if we hadn't
4 put in this program.
5 DR. WAKEFIELD: The point I was responding to with
6 Floyd was what might this do to supporting workforce, which
7 I know we say we have nothing to do with here. My comment
8 is, basically if you, for example, eliminated this $250
9 million out of GME for nursing and allied health and moved
10 it, moved the notion over, recommended that it be
11 appropriated out of the Bureau of Health Professions, maybe,
12 maybe not. It was that piece of what he was talking about
13 that I was commenting on.
14 DR. NEWHOUSE: But we said, keep it in the
15 Medicare program in the residency because it was really a
16 patient care cost. It's not clear that this is a patient
17 care cost.
18 DR. WAKEFIELD: I'm not disagreeing with what we
19 said. I was only responding to, what could this do?
20 MR. HACKBARTH: As I understand it, the trend has

been away from the hospital-operated programs towards programs run by academic institutions. It seems to me that that's relevant in evaluating the extent to which this is useful in dealing with the nurse shortage.

If in fact, for other reasons, everything has been moving toward the academic side, away from the hospital-operated programs, that suggests that there are substantial forces going the other direction that aren't really dictated by the availability of these dollars. The dollars are there, and still everything is going towards the academic programs, away from hospital-operated programs. Given that, this seems like an awful weak reed to use to deal with the shortage.

MR. DeBUSK: Glenn, I agree with you. You think about where the dollars are going, are they going in the right direction to help with the nursing shortage? I think are we all aware of how bad this shortage is right now? I've got an example I want to tell you about, just to reiterate the continuation of the shortage.

At Lincoln Memorial University we've got some

graduates who live in that rural area and the hospital in Roanoke has got a program now, if an LPN will come up there and work three days, put in the hours in three days, they'll pay them $42,000 for those three days to travel 200 miles and spend those three days. Now you want to know about a shortage. If you don't demonstrate what a real shortage is, I don't even know what we're doing here. We're certainly not addressing the shortage.

MR. HACKBARTH: I'm prepared to stipulate that the shortage is a real issue, a critical issue. For that reason, I think we ought to do real and substantial things about it. I think continuing this program the way it's been historically is just inertia. It's not dealing with the issues of today. So I'd rather see us redirect the money through a mechanism that's likely to be helpful, as opposed to just continue this because it's got nursing on the label.

MR. LISK: Just to provide you with some brief information. You received a packet from the nurse anesthetist groups and they had some information on the changeover from hospital-based to academic-based programs,

and in terms of the proportion of the programs therefore receiving some -- hospitals receiving money for some of those programs. It changed from in '92, 68 percent of those programs were receiving some support through Medicare, or hospitals receiving support for those programs. That declined to 30 percent in fiscal year 2000 in terms of how those programs were functioning. So that's one example.

There's a small number of those programs relative to overall nursing, 83 total, but that gives you some idea in terms of that shift.

DR. WAKEFIELD: Could I just ask Craig a quick question? Craig, to Glenn's point, do you have the data on how many of the hospitals that are provider-operated training programs operating associate degree versus diploma?

MR. LISK: Most of them actually I think are associate degree programs today. Of those 300 or 270 or so hospitals, less than 100 now today I think are diploma programs. So most of the others are associate degree, and there's a few B.A., BSN programs in there, too, and a few master's level as well. But it's not really an issue any

more of the diploma because those are really disappearing. So some of them are hospital-based associate degree programs that have developed from those.

DR. WILENSKY: We have four recommendations. Why don't we try and look at the first two, and then we can look at three or four or something different? The first one reiterates the position that Mary has mentioned that was part of our August 1999 report that to the extent that Congress wants to affect policies influencing the number and distribution of health care professionals, it should do so through specific targeted programs and not through Medicare.

DR. ROSS: We may Anglicize this a little bit. The original recommendation began just, federal policies, but we like to have actors. So if you read it as, if the Congress wishes to influences the number, and then just carry on.

DR. NEWHOUSE: I would insert, supported from general revenue, just for clarification, after specific targeted programs.

DR. WILENSKY: Any further discussion on this

before we do a vote?

All those voting in favor?

All those voting against?

All those not voting?

Let's look at the second one with data collection.

DR. NEWHOUSE: My issue here, Mary, is this seems to me to presuppose that we're going to have a payment system. And if we're not going to have a payment system, then we may just put a lot of burden to report data that will never be used.

DR. WILENSKY: I thought it was more the question of what -- we're not saying anything with regard to how we're going to try to assess enhanced patient value.

DR. WAKEFIELD: Enhanced patient care. That I don't have a problem with. I agree, because that would be consistent with where we've been historically.

DR. WILENSKY: Right. Is that if we're going to have data collection, it has to include some measure of differential quality.

DR. NEWHOUSE: I guess the issue is -- I mean, at

one level I agree with that. At another level is sort of, is the game worth the candle? We've got something that's a $300 million program. Do we really think we're going to demonstrate any differences -- be able to see any differences, even if they were there?

I think the original spirit of this was, if we were going to have some mechanism to pay for these people, we were going to have to collect data on numbers. We could answer then questions about, if you had more of them, did it cost more and so forth and so on. I thought that was where this was coming from.

DR. WILENSKY: Again, in the spirit of where we had started this discussion, I am comfortable that we're not being consistent -- although we can say that at a conceptual level, the theoretical expectation may be less, but that we're not being consistent if we don't attempt to see whether or not there is enhanced patient value as measured by quality differentials or other measures associated with institutions that do clinical training, as well as any difference in cost.

DR. NEWHOUSE: We relied on the literature basically in the case of teaching hospitals.

DR. WAKEFIELD: Have we even looked at the literature for this?

DR. NEWHOUSE: I haven't.

DR. WAKEFIELD: I haven't either.

DR. NEWHOUSE: But I just can't imagine that for this small a difference you could in fact see anything.

DR. WAKEFIELD: You may not, but to me it's an issue of consistency with our previous actions. And also what drives it a little bit for me is we really don't know.

DR. NEWHOUSE: I agree with you on both consistency and we don't know. The issue is it's going to cost us something to find out or to make the attempt to find out and I'm making a judgment about --

DR. WILENSKY: But nothing like $300 million. It's going to be a relatively small cost to do a study to try to demonstrate.

DR. NEWHOUSE: On the value side?

DR. WILENSKY: You do a sample of hospitals that

are involved.

DR. ROSS: Or you do a study that's appropriate to a $300 million expenditure.

DR. WILENSKY: Exactly.

DR. NEWHOUSE: All right.

MS. RAPHAEL: Is the study just relevant to the hospitals that are --

DR. WILENSKY: In order to try to establish whether or not there is enhanced value at such hospitals, you'd want to do a sample of hospitals that had clinical programs and then a sample of hospitals that you thought would be otherwise comparable, or of some variation in hospitals that didn't have clinical training programs, and to see whether or not there was some kind of differential quality or other measures of enhanced patient value. So you'd look at some range of hospitals, but certainly including hospitals like the ones that had clinical training programs who didn't have clinical training programs.

DR. NEWHOUSE: We're talking about all clinical training programs, not just nurses, right?

DR. BRAUN: If we're going to be consistent, aren't we talking about post-graduate education and not undergraduate education?

DR. WILENSKY: That is, of course, a problem that Joe mentioned, is that we're talking about undergraduate medical education. But again, to the extent that --

DR. BRAUN: So that's not consistent with --

DR. REISCHAUER: But I think it's very hard to think of the theory in which an undergraduate education would lead to enhanced value --

DR. WILENSKY: I agree.

DR. REISCHAUER: -- except with one definition of value. That is that this could be labor substitution on the part of the hospital, and therefore their costs are actually lower.

DR. WILENSKY: But we're talking about patient value.

DR. REISCHAUER: And it's value to them, but it's not value to the patient. Beyond that, Mary, the only thing you can hang your hat on is the teaching faculty --

DR. WAKEFIELD: Which is the point I was just going to make.

DR. REISCHAUER: -- and that they might change the behavior within these types of institutions.

DR. WAKEFIELD: Which is part of the rationale we used when we were talking about the availability of not just residents but the subspecialists with whom they were working, et cetera. That the dynamic, the mix of physician providers in teaching facilities was different than it was in community hospitals.

DR. REISCHAUER: I would wonder, how many of these institutions aren't also training residents and other people, and how you would ever disentangle this. I mean, it's a morass and you have an elephant walking around and you're trying to figure out what effect the mouse has.

DR. WILENSKY: Even if they have residency programs, there will be other programs that have residency programs that don't have clinical training.

Now to be perfectly honest, I think the likelihood of being able to find a difference is very small. But I

1 think that given in the spirit in which we have said we
2 ought to look at both increased cost and enhanced patient
3 value, that we ought to be able to look at either a
4 difference in patient outcomes for some kind of protocols,
5 or attempt to find some measure, or look at the literature
6 to see whether there's any studies that in fact show an
7 enhanced patient value with some definition in these
8 institutions.
9 I don't think it's very likely that you're going
10 to see the difference because of the kinds of variations
11 that you're going to see among these, and I think we ought
12 to focus on nursing because that's where the concentration
13 of the money is. But rather than just be dismissive that
14 it's not there, then I think we ought to make this
15 recommendation that we do such a study.
16 DR. ROSS: And maybe add at the end, and provide
17 enhanced patient --
18 DR. WILENSKY: Yes, the data collection has to
19 have a phrase at the end, and provide enhanced patient care,
20 measurable enhanced patient care.

DR. ROSS: Or whatever words we used before. I think it was just additional value or something.

DR. WILENSKY: Okay.

All those voting aye?

All those voting no?

All those not voting?

We are adding a phrase at the end that says, and provide enhanced patient care.

DR. ROSS: Glenn, your vote was?

DR. WILENSKY: You can do any of the three.

MR. HACKBARTH: I'll vote no.

DR. WILENSKY: Did you vote?

DR. NEWHOUSE: I voted, not voting.

DR. WILENSKY: All right, the next recommendation.

MR. LISK: This recommendation is -- you may want to add in, and there is commensurate higher cost -- say, patient care costs are higher and there's commensurate added value, or something to that effect, to reflect your higher value if you wanted to put that in there in terms of reflecting the previous statement.

The other issue is though, the eventually in here, is whether you want to -- the eventually should be in here or not. Because one says to fold it in immediately and then develop an adjustment. The other would be meaning that you would do this once you potentially have an adjustment and see what's there, if it's appropriate.

DR. WILENSKY: We're clearly not ready to vote on the second because we don't know the answer to it. We can consider either the first statement or we can look at the short run recommendation.

MR. LISK: Actually if you wanted, then you can actually consider the first statement in the series of short run recommendations here that you'd be considering, because you could make it a short run or -- it's a short run recommendation.

DR. WILENSKY: Really the alternative to that is, the first bullet on the short run recommendations as it's now listed is that eventually fold the pass-through into the base, or eliminate the current pass-through and appropriate additional funds for Title VII and VIII for nurses and

other, is an alternative to putting it in the base.

MR. LISK: Correct.

DR. NEWHOUSE: Is the thrust of this that we're preserving the pass-through because we don't know the answer yet?

DR. LOOP: Why don't you take the last sentence of this and put it on the previous recommendation? If the costs are higher from your study then you --

DR. WILENSKY: Only if you get also enhanced value. You then need two pieces to the study, both that the costs are higher and that they're something you want to pay for.

DR. ROSS: Since that's conditional, how about we put that in the text and bring back the discussion from the last report, which is what's motivating the study? That MedPAC has been supportive of additional payment where there's --

DR. WILENSKY: Of paying for additional costs --

DR. ROSS: Where there's higher cost and --

DR. WILENSKY: -- where there's higher value. I

1 think that's an appropriate way of doing it.

2 I don't know until we have some feedback that

3 we're really in a position to say that we should take the

4 money and either fold it into a base or have a direct

5 appropriation. So I think we just have to wait.

6 MR. HACKBARTH: By asking for this study, are we

7 going to put ourselves in the position where if they don't

8 act on doing something through another more direct means,

9 because there's this study and a potential future Medicare

10 adjustment hanging out there, and so we end up just sort of

11 frozen where we are?

12 I'd just rather say -- and I know I'm in the

13 minority but I will just go ahead and say it anyhow. Let's

14 not do a study that we don't think is likely to be

15 productive. Let's take it out of Medicare and do something

16 meaningful through the direct appropriation channels. This

17 is a real issue, a critical issue. Let's get on with it.

18 Let's not study potential future Medicare adjustments.

19 MS. RAPHAEL: I think the peril in that approach

20 is that if you look at what the appropriations are now,

they're much less than this $300 million, and how would we know that this $300 million in fact would ever get transferred?

MR. HACKBARTH: Ultimately we will never know. It's in Congress' hands what happens. All we can do is say what we think should happen.

DR. NEWHOUSE: And the presumption is that the $300 million is actually doing something useful instead of just dropping down out of the sky on some hospitals.

DR. WILENSKY: I agree that makes more sense. Again, it was within the spirit of where we were, of dismissing whether or not there is any measurable enhanced patient value, when Mary is rightly calling our hand that we said that that was the approach that we were going to do.

MR. DeBUSK: If we've got $300 million falling from heaven, why don't we do something constructive with it, like train more nurses?

DR. WILENSKY: But the problem isn't training.

DR. WAKEFIELD: But we're not saying, take this money and move it en bloc over into the appropriations side

of the ledger. We can't do that, and we're not saying that. So we leave it to the discretion of our colleagues -- colleagues is an overstatement -- the senators just a mile from here, and whether or not they choose to take this $250 million and move it over.

Some hospitals I think would say right now that, yes, they run training programs, but it's extremely difficult to keep those training programs -- to provide learning environments for those students. They have every incentive to do it because they want to recruit, retain, et cetera. But you've got front line shortages of health care, of nurses -- using nurses as an example -- and then you're trying to superimpose on top of that a training operation, when these nurses are already stretched like this [indicating].

So I'm a little concerned if we say, okay, we're going to take that money back from the hospitals, that that's not going to even jeopardize what they've got available right now, or at least what they're choosing to put into their resources. It's a tough environment just to

provide patient care, let alone putting students into that mix and expecting all things to work smoothly.

DR. WILENSKY: We are, of course, in the first recommendation indicating that to the extent that the Congress wants to try to alleviate the nursing shortage, they ought to do it through direct policies outside of Medicare like the Bureau of Health Manpower or any of the other policies that they can come up with.

So I think basically our first recommendation, it's only a question of whether we suggest taking the specific money and moving it, and I think until we have done the study that we had said it was appropriate. So I think we ought to stay with our first two recommendations and stop. I don't think there is anything more to say at this point.

We're not going to vote. We are going to ignore that and the follow-on recommendations. I think at this point we don't have anything more to say than if Congress wants to try to influence it, it ought to do so outside of Medicare.

Next session on access?

MS. MUTTI: This presentation is on rural beneficiaries' access to care. The draft chapter is at your Tab G in your background materials. Before I start I want to offer a couple of caveats. One is that I have just recently taken responsibility for this chapter so some of the material is somewhat new to me. Fortunately, I have a few of my colleagues who have worked on certain parts of it here with me, so between us we should be able to answer your questions, and of course, if not, we'll get back to you.

Second of all, I'm sure you may have noticed as you were reading this chapter that there are certain holes in it, parts that we just didn't quite get a chance to fill out, collect all the information. We certainly intend in the next week or so to come back and address that. Particularly in the area of the providers that are located in rural areas, that's really short on material right now and really just placeholders there at the moment.

In this presentation I will summarize the chapter and ask for your feedback on one proposed recommendation

that was discussed at the last meeting, and then ask for your feedback also on overall content and tone. I think tone will be very important in this chapter.

The first part of the chapter assesses rural beneficiaries' access to care. It begins by a discussion on the challenges of measuring access to care and judging what is acceptable access to care. As we discussed at the lack meeting, there's a lack of a perfect benchmark or a definition of what is acceptable access to care. So we acknowledge that going in.

Also this chapter relies largely on MCBS data, and there are limitations to that data. While it provides a good overall national picture of access, it is not capable of reaching every pocket in the country, so we just need to bear that in mind as we consider the results.

As was discussed at the last meeting, rural beneficiaries are largely satisfied with the availability and the access to their care, both in absolute percentage and in comparison to their urban counterparts. For example, in terms of availability of medical care, 93 percent of

beneficiaries were satisfied across the board, both rural and urban. Satisfaction with specialist care was 95 percent, trouble getting care was just 3 to 4 percent. That was pretty consistent rural and urban.

The claims analysis supports these survey findings in terms of that both the urban and the rural beneficiaries showed up to be relatively similar, but there was certainly a difference. The claims analysis showed that fewer beneficiaries were getting their needed care.

There were two exceptions to these overall positive results, and that was remote rural beneficiaries did seem to show a little bit more concern for their access, and pretty much across the board the rural beneficiaries were more concerned about the high cost of care.

So we tried to come to some conclusions about this information, this analysis, and we start out by saying it's difficult to make a definitive conclusion about the effectiveness of Medicare's rural policies improving access. It's just there's not that link that will definitively show whether these programs have been successful, whether they

1 were improperly targeted and that we didn't reach some of
2 our most remote beneficiaries, or that there was a lack of
3 underlying need for them in the first place.
4 In addition, in this chapter we also note, as I
5 said, that there's a lesser degree of satisfaction with
6 access to care in remote rural areas, and we state that this
7 warrants continued attention. But to balance out that, we
8 should also note that the situation does not seem dire,
9 especially taking into account some of the use data that you
10 heard earlier this morning. We were unable to offer any
11 systematic way of monitoring access in these real remote
12 areas in the future, but we do acknowledge that it's
13 important to keep an eye on it.
14 Then given concern that rural beneficiaries
15 expressed about cost of care, MedPAC plans to study out-of-
16 pocket cost and possible changes in cost sharing, such as
17 coinsurance rates, that type of thing.
18 Our recommendation, we do have one recommendation
19 in this chapter. This was discussed at the last meeting.
20 It's that the Secretary should evaluate why rural

beneficiaries are not better represented in programs that cover Medicare cost sharing.

This recommendation reflects the fact that while rural beneficiaries are poorer than average than urban beneficiaries, they are not any more likely to be enrolled as a dual eligible to participate in the QMB program or the SLIMB program. That's qualified Medicare beneficiaries and specified low income Medicare beneficiary program. This might be particularly burdensome that they're not participating in these programs given that they pay a higher percentage out of pocket for Medicare-covered services and that some of their coinsurance may be going up, particularly OPD.

As you consider this recommendation this meeting, you might want to think if this reaches your threshold for something that you want to recommend the Secretary do a study on. Particularly, there has been other work in the past that has looked at the fact that there are relatively low participation rates in these programs across the board.

There are some suggested, sort of known

explanations for why some of these things occur. Certainly, some states, southern states with substantial Medicare rural populations may have very low poverty thresholds for even being eligible to be a dually eligible for both Medicaid and Medicare. Other barriers that have been identified by other studies are the fact that you have to have a face to face interview in order to be eligible for QMB or SLIMB. These are probably a likely barrier for why that would prevent rural beneficiaries from participating.

DR. WILENSKY: Anne, is there a reason that the focus is on evaluating on why something hasn't happened as opposed to directing the Secretary to find strategies that would increase enrollment in those programs that reduce cost sharing that are available?

MS. MUTTI: I don't think that there was a strong feeling going into it. I think that would be an acceptable way to reword this in a more positive way.

DR. WILENSKY: To the extent that we have programs like QMB and SLIMB and that enrollment is always an issue, directing more effort be made to increase the enrollment of

rural low income individuals in existing programs would be better than --

DR. NEWHOUSE: Why just rural?

DR. WILENSKY: Only to the extent that -- to increase in general, particularly in those areas where they're income adjusted differentially, poorly represented.

MS. MUTTI: Again, so just rewording, the Secretary should identify strategies to improve rural beneficiaries representation in these programs, something like that?

DR. WILENSKY: Right. I think in the text the point that Joe just raised, I think it's appropriate to attempt to increase enrollment for qualified individuals in QMB and SLIMB in all areas. But this is a chapter on rural access so I think we should particularly focus the recommendation on that.

MS. NEWPORT: Just a point of clarification for me is that there was reference in the chapter about Med supp coverage, and we've talked about the M+C stuff. This recommendation is just clearly aligned with the SLIMB, QMB

government programs?

MS. MUTTI: Right, and duals.

MS. NEWPORT: Maybe we want to say that.

MS. MUTTI: In terms of covering Medicare cost sharing? Yes.

DR. WILENSKY: I also was confused about that, because my initial reaction in looking at the wording was that's because there aren't any M+C programs.

MS. MUTTI: Right, we were trying to avoid having to define QMB and SLIMB in the recommendation.

DR. ROSS: Because we couldn't use the acronyms in the recommendation. But we'll be clear about that in the text.

DR. NEWHOUSE: My reaction actually is similar to the discussion that we had this morning about quality differences. That is, the percentage without any form of supplementary insurance is 17 versus 14, which sounds like a small difference relative to the take-up rate in these programs, which I think is more like 60 or 70 percent across the board. So it's in that context I think we should talk

about -- it's really very similar to me to this morning's discussion.

DR. WILENSKY: Okay, then to reword this recommendation, just to make efforts to increase the enrollment in programs that cover premium deductible and cost sharing for eligibles.

DR. WAKEFIELD: Was it in this chapter or someplace else where you reported out data on Medicare beneficiaries' perception of access to or utilization of services -- I can't remember what the issue was -- related to cost? It's in this chapter and it's in this section? Because I think that's an important point to appear alongside of this.

DR. WILENSKY: Maybe you could try to reword this slightly and let us look at the specific language in the morning. But my sense is there's agreement on the sense of the recommendation. We'll look at it and then do a vote in the morning.

MS. MUTTI: I just want to be sure that you're -- there's one more slide and just one more point to make. The

1 second part of the chapter talks about Medicare rural
2 programs, for lack of a better term, and it summarizes
3 hospital-based and rural health clinic programs, and tries
4 not to overlap with what Jack has done but we'll refer to
5 that. But we really spend most of our time talking about
6 the Medicare incentive payment program and then telemedicine
7 policies.
8 As we discussed at the last meeting, we weren't
9 going to make any recommendations with respect to the
10 Medicare incentive payment program because we were awaiting
11 an evaluation by RAND, the final report which is due to come
12 out later this year and you were looking forward to having
13 those results before making any recommendations. Also
14 there's an ongoing effort to change the HPSA definition that
15 would be interesting to see how that turns out. So
16 consistent with that, we have no recommendation in this
17 draft.
18 At the last meeting we also talked about draft
19 recommendations for telemedicine, particularly the store-
20 and-forward technology. Upon further reflection, we would

recommend that that may be too premature to go on that route. We would point out that BIPA made a lot of policy payment changes that have even yet to be implemented. It might be worthwhile to see how those play out, get a little experience with that.

Also, there are two demonstration projects that are going on that are financed through HRSA, I believe. I may have the wrong agency -- but not HCFA, both in Alaska and Hawaii that are using store-and-forward technology. BIPA required that Medicare reimburse store-and-forward technology in those two areas. So in a sense, there is a demonstration on reimbursing this technology and it may be worth waiting for some results from that before we go forward and make our own recommendation. So at this point staff have no recommendation on this topic.

DR. WILENSKY: Joe, did you have a comment?

DR. NEWHOUSE: This is really a comment on tone. We start off, the first fact we come to is the disparity in resources in terms of doctors per person in rural. That really only makes sense if you say that the rural population

tends to use rural providers, although you've been a little better here and say, it's not surprising that they travel to urban areas. But it may also be the case that the nearest provider is actually in a metropolitan area for the -- there's a substantial share of the non-metropolitan population that lives in counties that are adjacent to metropolitan areas, as our data show. For that group, their closest doctor may be in the metropolitan county.

This presumes that if you're in -- the rural population uses only rural providers, and the metropolitan only uses metropolitan. That last assumption is about right, but the first assumption needn't be right.

So maybe just pointing toward the fact that although there's going to be these disparities, in fact when we get to what we think are better measures of access later in the chapter, those measures don't show anything like the kind of disparities you're showing in the resources here. This is what's usually trotted out to indicate problems. In fact we have quite a bit more to say than this, and we ought to signal the reader that this is certainly not the whole

picture.

MS. MUTTI: So I'll just revise the lead-in to that discussion to point that out.

DR. WAKEFIELD: On the Medicare incentive payments I'd just ask you, if you get 20 seconds to maybe give Gary Hart a call out in the state of Washington. I think he's looking at issues around participation rate of physicians in this program and what might be driving their selecting in or not. Because at least anecdotally there's been some concern about the audit rate on bonus payments. Given that these are not very high at the front end, it may well be that there's something else going on and he might be able to tell you something that could be incorporated in here.

I also have a number of comments on the discussion about rural health clinics and ambulance payments, et cetera, but I am sure my colleagues here would do me if I insisted on going through all of those, though you asked for tone. So I'll go ahead and just e-mail them to you or something, if that's all right. But I do have a number of comments on tone.

DR. BRAUN: I just wanted to bring up, in the area where you're talking about the propensity to seek care you talk about there being very little difference even in remote areas, but then the paragraph goes on to theorize on potential barriers to care. I'm wondering, that doesn't seem to hang together. I'm particularly a little bit concerned about the anecdotal situation with the dental. Somehow there's a value thing in there that worries me a bit.

Also under the claims analysis findings, I think that's a good opportunity to talk about neither 71 nor 73 percent are acceptable values of needed care. I think that's a good place where we could bring that out.

There's one other thing I wondered about. On the top of page 15 you have, by design, Medicare does not provide complete comprehensive health care coverage. I'm just wondering what the by design is. I'd rather see that left out, because it seems to me when Medicare came in, the design was to have it sort of equivalent to what would be private insurance. The fact that it's wandered off from the

original design is something else. But I really don't think it was by design, at least not from the beginning.

MS. MUTTI: I have no problem with that. Good point.

On the propensity to seek care, I'll go back and see how it reads. The intention was to lay out the groundwork for saying, there's reasons to think that there would be a lower propensity for rural beneficiaries to seek care, whether it's referral patterns or sociocultural reasons, but the research we did didn't show that disparity. But let me make sure that it reads right.

DR. WILENSKY: Any additional comments? By all means, Mary, give the detail --

DR. WAKEFIELD: To them, right? Though I'd be delighted to go over them with you right now, believe me. I have all my notes right here.

MR. DeBUSK: Let's vote.

[Laughter.]

DR. WILENSKY: Do you have enough guidance for revisions, particularly with Mary's extensive comments to

1 come your way?

2 MS. MUTTI: Yes, so the two points that I'm trying

3 to -- actually just to be sure -- is that we want to be more

4 positive and identify strategies to increase participation

5 in these programs, and we want to better define what these

6 programs are by saying that they are programs that cover

7 premiums, deductibles, and coinsurance.

8 DR. WILENSKY: Government programs. When I looked

9 at this my immediate response, since most people attempt to

10 cover the coinsurance or missing pieces of Medicare through

11 private supplementation, is I didn't immediately think of

12 public programs.

13 MS. MUTTI: Right. No problem.

14 DR. WILENSKY: We'll then do the vote on that

15 tomorrow. Any further comments from the commissioners

16 before we go to public comments?

17 Thank you.

18 We're going to turn now to public comments. I'd

19 like to ask the commenters to try to keep their comments

20 pointed and brief.

MS. FENNEL: Thank you. I'm Karen Fennel. I'm senior policy analyst with American College of Nurse Midwives. I think earlier Craig pointed out to you under Part B billing of the Medicare program, which is where nurse midwives bill when supervising students, that we can't get reimbursed. You might wonder why we're so concerned about Medicare when you only look at about 300,000, a little over 300,000 deliveries a year in the Medicare program.

However, what's happening to us is that Medicaid and private insurers are looking to Medicare and they have decided not to reimburse our faculty. We are having clinical site after clinical site close down. I have a major program that this was one of the major reasons they will close this year was the lack of being able to collect monies when supervising students.

So essentially what's happening is our nurse midwifery faculty, who are not employed, by the way -- the majority of our faculty are not employed by the hospitals. They are in their own practices. They can't collect and there's a free service given.

We would hope that as you look at education and cost of training, not just of the staff nurse, that you would also look at the advanced practice nurse as well, and possibly give some guidance to HCFA and to Congress on this issue. We'd be glad to provide you more information.

Thank you.

DR. WILENSKY: Thank you.

MR. GRAEFE: Thank you, Gail. Fred Graefe with Baker & Hostetler on behalf of the American Health Science Education Consortium, which is the 700 or so hospitals that participate in the nursing and allied health pass-through program. I think it was a fair resolution in adopting the two recommendations that you did.

A couple of comments. The Congress in its wisdom in about '88 or '89 capped the number of hospital-operated programs, so that number has remained steady. That's why there has been "no growth" in the program in additional hospitals building and operating and owning hospital-operated colleges of nursing and allied health. So that explains why, in one sense why the growth in other academic

areas has occurred. It's also occurred -- obviously, you're the health policy experts -- because payers have demanded additional non-physician health professionals; to wit, APNs at Oxford in New York City and other places.

Finally, Congress is actually considering this issue -- not as we speak since they're on recess -- but they will be addressing this issue, I'm assured, in the Medicare reform this year on expanding the nursing and allied health program to include non-hospital settings, if you will, in the Medicare program and in some appropriated accounts.

Finally, I think making a suggestion about moving Medicare dollars, transferring to appropriated dollars would be viewed I think by people on the Hill as sort of kicking the can down the road. It really doesn't answer the question of what to do about increasing the supply of nurses. I think that Congress is looking at this year. I gave Craig a copy of all the bills that have been introduced to date. There are two identical bills introduced in the House and the Senate that deal with the Medicare issue specifically.

So thank you for your time and attention to this issue.

MS. HELLER: Hi, I'm Karen Heller with the Greater New York Hospital Association. I wanted to talk a moment about the issue of the labor share, of the standardized amount. I have a very special interest in this because any redistribution, about 25 percent of the money would come from my members in New York City. I modeled the 63 percent number yesterday because that's simply the number I had heard. It was about a $2 billion redistribution over five years, about $450 to $500 million in a single year. It's real money to us, much more than the aggregate, bottom line margin of our hospitals today.

At any rate, I'm very, very gratified and reassured by the conversation that you had. I feel that your interest is not in arbitrary reduction of the labor share, but is sincere interest in looking at what parts of costs are driven by local versus national markets.

Now my comment. Just as you were saying that the assumption about all of the labor components of the

marketbasket are local, likewise there's an assumption that all of the non-labor components are national. So as we take our sincere look at what the components mean in terms of local and national, I just want to make sure that you will ask HCFA to look at both the labor components and the non-labor components, because it's quite possible that we want a cross-sectional input price adjustment on the non-labor component as well as the labor component.

My intuition is that it would be a wash in terms of the part that's adjusted today, because my familiarity with empirical analyses have shown that if you look at the wage index as an explanatory variable, the coefficient is around 70 percent.

So I just appreciate the ability to say that and thank you very much.

MS. LOVE: Hi, Marian Love from the American Organization of Nurse Executives. I just want to make a couple brief comments on your conversation about nursing education today.

First and foremost, we would love to see the

Bureau of Health Professions division of nursing play a more significant role in the preparation of nurses. Unfortunately, our history from the nursing community with regard to securing and expanding our appropriations has not inspired great confidence in this approach as a sole source of funding for nursing education.

To that end, I think also I want to address the question of, is there a potential for inaction as a result of taking some more time to examine the issue of, are there enhanced patient care costs and value in those facilities where Medicare is providing pass-through dollars. I think the answer to that is, given what we are seeing in the media, in the private market, and in the congressional action that was mentioned by one of the previous commenters, I think the response to that is, no. I think there's a lot of efforts ongoing and that will continue, and we support those initiatives.

Lastly with regard to removing the current funding from those programs that are ongoing, one of the issues that we're dealing with right now is trying to maintain the

ground that we have as far as preparing a workforce, let alone putting ourselves in a position where we might see the closure of these programs as a result of loss of funding and then having a year or two delay in reconstituting those programs elsewhere. At this point, with this nursing shortage we can't afford to lose that ground in the interim.

So we do appreciate support for the ongoing role of Medicare in those programs right now and hope, as we explore other ways to provide a sufficient workforce, that we can address those issues down the road.

Thank you.

MR. CALLEN: Mark Callen, Health Care Association of New York State. First of all, I would like to thank Karen for pointing out the dramatic impact that redistribution can make on a technical improvement to policy. I'd like to put a picture around that.

In New York in 1999, two-thirds of our hospitals had operating losses; about twice the number that losses in '97. With respect to Medicare, almost 40 percent of New York's hospitals had negative margins in 1999, compared to

1 26 percent in 1997.

2 In the midst of this, we are experiencing a

3 significant shortage of nurses, aides, therapists,

4 pharmacists, and other health care workers. The average age

5 of an R.N. in New York State is 48. The average retirement

6 age is 52. Only 10 percent of working RNs in New York are

7 under the age of 30. Enrollment in nursing programs

8 declined by 19 percent over the past five years.

9 Certainly we need a long term solution, but there

10 is the short term impact of increased labor costs that our

11 hospitals are about to experience. We can't afford any

12 reductions in Medicare reimbursement as a result of

13 technical improvements that redistribute money. We would

14 really appreciate it if MedPAC staff would, as part of any

15 presentation, show the movement of money on some of these

16 policy issue.

17 Finally, I think you can understand in the

18 financial state that we're in, we do support the AHA's

19 agenda for getting money to address the workforce shortage

20 problem.

Thank you.

MS. COYLE: Carmela Coyle, the American Hospital Association. Like to thank the Commission, as always, for their thoughtful discussion today. Four points.

First of all, purpose. At least as I sat back and listened today, I remain a bit confused around the objective of this very important report that's going to the Congress on rural issues. I think one thing that was clarified is the purpose of the report was not to increase the margins of rural hospitals. Yet the analysis that you looked at and every option that was evaluated was evaluated based on whether or not it increased margins to rural hospitals.

It was also discussed that the purpose was to provide access to quality care in rural areas, and was also suggested, I think by the chairman, that it's about improving Medicare payments. But I'm not yet clear on what improving Medicare payments means. Does that mean to make payments more accurate, to make them more equitable, to limit anomalies, to make services more accessible?

To that point, would urge the commissioners to

review one of the recommendations you approved today on the issue of base payment rates where the recommendation reads, "conclude no change needed, reflecting belief that our recommendations will produce equitable payments." Everything I've heard today suggests that you really weren't trying to achieve equity and equitable payments. You may want to review that language.

Would also, to that point, suggest that this recommendation was written before you decided what you were going to approve. So you may want to consider redrafting that recommendation.

DR. WILENSKY: Excuse me, Carmela, that is not a recommendation and should not be characterized as such.

MS. COYLE: I'm sorry, I thought you approved recommendation number one.

DR. WILENSKY: It's not a recommendation. It indicates options. It is consistent with where we believe we are, which is that we have made a series of recommendations that attempt to refine payments under Medicare in appropriate ways.

We have looked to see how they would affect rural hospital and urban hospital margins because, as I thought was rather well indicated in the early discussion that we had with Julian's chapter and we had in the preceding Commission meeting, that what we are attempting to do is to, in our choices of just having money available to particular sectors like rural or urban or inner-city, is try to refine and improve our Medicare payments, and in doing so may relieve some of the pressures that were indicated.

The sense of where we ended up is that we are comfortable making specific recommendations and we're not comfortable in making a recommendation with regard to changing or equalizing base payments. So by implication, we believe that the appropriate steps to take now are to do these specific targeted changes and to not make further gross changes.

So it is consistent that that is the sense of the Commission. It was not a specific recommendation per se, nor was it voted on.

MS. COYLE: Thank you. That's a helpful

clarification.

To my second point, which is on the topic of information. As always, staff has done a significant amount of good work. But raise the question whether commissioners have all of the information, or at least some of the information that might be both helpful, important, and desirable.

You have talked a lot today about the dollar impacts. Other people have mentioned them. Just a couple of questions. On the DSH cap recommendation that you voted, had a dollar figure of $180 million. Does the Commission know whether that's a one-year impact, a five-year impact? On the low volume adjustment, the $22 million, is it a one-year impact, a five-year impact? And did you know that at the time that you were voting? Are these things new money? Are they budget neutral?

Just not clear. I hope it's clear to you, but from our perspective in the audience it wasn't clear. May be helpful to have that kind of information as you're making some very important decisions.

Third point is one of practicality. On the issue of the labor shares. Other people have commented. I'd like to comment from a different perspective. That is, having the Secretary study that may make some sense.

But if you think about what the Secretary would have to do to collect that data, presumably to actually inform this commission and policymakers, you would presumably want hospitals to collect information on every legal contract, computer contract, labor-related contract that they may have. To then report whether that contract is locally engaged or nationally engaged. To understand what the wage rates then are to really be able to get a sense of this issue.

So while the Secretary may study it, I think it's going to be very difficult for them to actually achieve that. And I think the burden of actually trying to do that well would be significant, even for you and your organizations around this table, to be able to quantify that.

To my last point and that is one of process. The

nature of my comments are somewhat limited and very different. I have said this for the record before, but would entreat, Madam Chair, would ask that this commission please consider allowing those of us who sit here, who are either greatly affected by the important decisions of this commission or people we represent are greatly affected by decisions of this commission, to comment as part of this public, open process before you take your votes as opposed to at the end of the day. I think the nature of our comments would be quite different if we were allowed to do that. So would just ask your consideration in that matter.

Thank you.

DR. WILENSKY: Let me make sure -- I hope that this is not new information for the commissioners, that the numbers we heard were one-year numbers unless otherwise said, and that we have indicated when they are budget neutral, and when they are not budget neutral that is suggesting additional monies. The largest non-budget neutral recommendation I'm aware of was basically an extension or a partial reiteration of a previous

recommendation with regard to DSH money that had quite extensive discussion about the fact that we were making a recommendation regarding new monies.

We are usually quite careful about making recommendations that involve new spending, indicate that, and indicate something about the implications of our recommendations. I regard the fact that we did not have more extensive discussion on that particular piece of recommendation is that it was a partial reiteration of our previous recommendation with regard to DSH, partially because part of it was already picked up in BIPA and partially because we did not feel it appropriate to make the full extensive recommendation at that time.

But I certainly assumed that the commissioners were aware that we were talking about one-year money, and additional money unless budget neutrality was specified.

I would be glad to take up with commissioners at our retreat this question of whether we have public comment before we have recommendations. But these are all recommendations that have been on the table since our March

meeting so I don't think there was anything that was new fundamentally in substance; obviously, wording changes.

MS. TAYLOR: My name is Pat Taylor. I'm an independent consultant and I specialize in rural health policy issues. I want to thank the Commission, and particularly the staff, for the wonderful amount of new analyses and information that we are going to have about the rural health care system and Medicare as a result of this report. It's just wonderful to be getting it.

But I do want to just comment very briefly on the limitations of the Medicare current beneficiary survey, using it for understanding what's going on with rural beneficiaries. That survey uses a highly clustered sampling frame, so there are 27 states in which there are fewer than 10 members of the sample, and that includes eight states which has no non-metropolitan members at all. So I think it's inappropriate to break it down by all these urban influence codes, as I think you have a chapter that's going to do that.

Then the second point is, in this sample in 1992--

DR. NEWHOUSE: Did I understand you to say there were some states that had fewer than 10 people in the MCBS?

MS. TAYLOR: Twenty-seven states.

DR. NEWHOUSE: That includes zero people presumably.

MS. TAYLOR: Yes.

DR. NEWHOUSE: I didn't understand how you could have clustered sample --

MS. TAYLOR: There are eight states that have no non-metropolitan members.

The other thing is, in the most remote urban influence codes, I estimate there are about 500,000 beneficiaries that live in this most remote code areas, and there are only 25 in the 1992 sample, which I think has not been changed much, the sampling design. There were actually 23 sample members from that category. That's just such a total under-representation, I think you can say nothing based on that survey about those people.

MR. FAY: Hello, my name is Tony Fay. I'm with Providence Health Care. We operate 55 mainly rural

hospitals throughout 17 states. I'm very interested in the work of the Commission. This is my first meeting.

The point I'd like to make is that BIPA went a long way in terms of providing DSH funding to rural hospitals that was not previously available, and we think the Commission's recommendation goes a step further. But I can say as the operator or working with a company who operates 55 rural hospitals that that is probably the biggest payment disparity between urban and rural hospitals. We would hope that eventually the formula, the same rate would be paid to rural hospitals that is paid to urban hospitals in terms of Medicare DSH.

DR. WILENSKY: Commissioners, you have a half-hour before we reconvene for dinner, and then we will reconvene tomorrow at 9:00.

[Whereupon, at 6:32 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Friday, April 13, 2001.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, April 13, 2001
9:02 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
AUTRY O.V. DeBUSK
GLENN M. HACKBARTH
FLOYD D. LOOP, M.D.
ALAN R. NELSON, M.D.
JANET G. NEWPORT
CAROL RAPHAEL
ROBERT D. REISCHAUER, Ph.D.
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA PAGE

Assessing the implications of the outpatient PPS for quality and access (Henry Miller, Ph.D., president, CHPS Consulting, Dana Karr, managing associate, CHPS Consulting) 3

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P R O C E E D I N G S

DR. WILENSKY: Good morning. Chantal, do you want to introduce our guests?

DR. WORZALA: Good morning. Our first session today is a presentation of findings from an external research project on the potential impact of the outpatient PPS on access to quality care.

You may recall that last June we recommended that the Secretary monitor implementation of the outpatient PPS to ensure continued access to quality care. As a follow-on to that recommendation we contracted with the Center for Health Policy Studies or CHPS to take a preliminary look at the issue. Our goals in letting this contract were to identify potential problems in both the short and the long-term and to consider how quality and access could best be monitored in this particular setting.

With us today to present the results of their work are Henry Miller, President of CHPS, and Dana Karr, Senior Director and Project Manager. They'll be presenting the full scope of their findings, but also highlighting the

findings pertinent to rural hospitals.

Dr. Miller has considerable experience with the design and implementation of outpatient prospective payment systems for private payers, state agencies, as well as the Medicare program itself. Both Dr. Miller and Ms. Karr have worked extensively with hospitals in preparing for and implementing the Medicare outpatient PPS.

So with that, I'll turn it over to them.

DR. MILLER: Thank you. I just quickly want to introduce the study and tell you that the things I want to talk about this morning are findings, the specific findings that relate to rural hospitals, and then the issues relating to the ongoing monitoring of access to quality care for hospital outpatient services.

Certainly, as Chantal has just indicated what the impetus for the study was, this is a study that was referred in the Balanced Budget Act to MedPAC and certainly has been an issue of some concern, as to whether or not this new payment system will affect access to quality care for Medicare beneficiaries.

I identified, as did Chantal, what the goals of the study were, so it isn't really critical to repeat those, other than the focus was to get information on the perceptions of the effect of the OPPS on access to quality care. The study had to focus on perceptions because the implementation of the OPPS is new, only since August 1st, and it is difficult to tell what the results or what the impact is going to be.

Our approach included a literature review and then the bulk of the approach, the bulk of the investigation, was based on interviews with key informants. We interviewed about 80 people. The 80 people, about 40 percent of those people, about 32 or 33 people were hospital administrators, representing urban, suburban, rural hospitals, and academic medical centers. But we also spoke with representatives of trade associations, representatives of accrediting bodies, consultants and researchers, as well as payers and government people, people from both HCFA and AHRQ.

I think the summary of the findings is pretty straightforward. Number one, it's too soon to tell whether

or not there's going to be an access to quality care effect that the OPPS will have. There's reasons why it's too soon to tell. One reason that's most important is that the system, as it was eventually implemented through revised regulations, has a fairly sufficient array of transitional payments, hold harmless clauses, and grandfather clauses that will limit the impact in the short term.

In this short term period, the impacts that have been discussed, that were discussed with us as being most important, were the ones that you would suspect, concerns about changes in billing practices, concerns about coding, and concerns about compliance where the hospital have had to make significant changes, specifically in their coding, in order to have their claims properly classified and paid under the APC system, and their concerns about compliance pretty much relate to coding.

Their concerns about billing also relate to the newness of the system and the difficulties that they encounter in trying to determine how bills should be properly presented and what kinds of problems can occur,

1 primarily because this is a new system and the
2 intermediaries are not as up to speed on it as they will be
3 in a period of time. So the concerns about billing pretty
4 much related to that.
5 MR. DeBUSK: Let me make a comment here. I'm out
6 there on the firing line every day, seeing these problems
7 with billing coding and compliance. You talk about a major
8 area of problem -- well, you can identify the problem. It's
9 trying to solve the problem. But education is the problem.
10 HCFA nor the intermediary, neither one, does a
11 very good job of informing the hospital, the billing
12 department, about the codes, how to go about it. It's
13 lagging behind tremendously. So you've got your hospital
14 caught in a transitional period. And when the costs is --
15 got to be tremendous now. Of course, ultimately how that
16 affects access and quality -- well, I'll let you go on from
17 there.
18 DR. MILLER: Just as a response, the comments
19 you're making are in fact the same comments we heard in our
20 interviews, that it was very difficult to get appropriate

information from fiscal intermediaries and from HCFA. And very frequently, people were frustrated by not knowing who to ask.

MR. DeBUSK: I think one of the problems here is we don't address in the beginning here of the process, the intermediary and, of course you talk to the intermediary and they say well, we don't have the funds to train. I think there's some truth to this.

I think on the front end we fail to provide enough revenue so they can do this thing properly. So we halfway do it and then we get halfway results, and then we get full measure costs that ultimately is a mistake on our part on our approach.

DR. MILLER: As this slide indicates on quality and access, aside from these other effects that we were just talking about, there hasn't been that much consideration of them so far. But there have been some concerns and some speculation that was offered in our study.

There are concerns relating to the payment system's design itself. Some of those concerns are not

1 necessarily obvious. The payment system design, for
2 example, includes an inpatient list where Medicare will only
3 pay for certain services if they're provided on an inpatient
4 basis.
5 While that is seen perhaps by many as a positive
6 quality effect, it's also seen by some hospitals and others
7 as having a negative effect because the hospitals have
8 become used to providing the services on an outpatient
9 basis, they've developed protocols for the provision of
10 those services on an outpatient basis, and many believe that
11 they are most appropriately provided in that way. So that
12 inpatient list has turned out to be somewhat of a two-edged
13 sword.
14 The same thing can be said about the copayment
15 requirements. Whereas the copayment requirements are quite
16 beneficial for people who are using hospitals where charges
17 were quite high, the copayment requirements are gradually
18 being reduced for those people. But on the other hand, and
19 this is something that specifically affects rural hospitals,
20 the copayment requirements actually result in higher

1 copayments for rural hospitals where the charges have been
2 fairly low in the past. And there are some concerns about
3 access in those rural hospitals because they are concerned
4 that the Medicare beneficiaries are not going to be able to
5 make that copayment payment if, in fact, they have to do it
6 themselves and don't have a supplemental policy.
7 DR. ROWE: Dr. Miller, do you think the study was
8 done too soon? I mean, if it's too soon to tell, maybe we
9 shouldn't have done it later, we should have done it later.
10 DR. MILLER: One aspect of the study, the part
11 that we're talking about now, it certainly is very early.
12 The other aspect of the study though, for us, was the
13 identification of methods that can be used to monitor change
14 in access to quality services over time.
15 DR. ROWE: Accepting the view that an investigator
16 never feels that it's not time to do a study, but holding
17 you completely harmless -- you know, in fact, if you were
18 going to do this again, and guaranteeing you would to it,
19 and all the rest of it, would we have been more thoughtful
20 if we had planned together with you and probably done this

1 somewhat later? That's all.

2 DR. MILLER: I'm sure that there would be more

3 definitive results later, but the question would be how much

4 later? In fact, it would not be something -- you couldn't

5 say okay, in August of 2001 the system will have been in

6 place for a year, is that the right time to start studying

7 the impact? In fact, I think these impacts are going to be

8 very gradual and picking the time would be difficult. But

9 without question, as time goes on, the results will be much

10 more easy to identify.

11 In terms of some of the other possible concerns, a

12 number of hospitals and others reported concerns about the

13 shifting of services from one setting to another, from the

14 hospital outpatient department to the physician's office.

15 Also concerns about the consolidation of services. For

16 those services that were not paid at a sufficient level in

17 the APC system, the concern was that some hospitals and

18 hospital systems would consolidate the availability of those

19 services within their systems or within an area which, of

20 course, would diminish access as it currently exists.

There was some concern among rural hospitals and in a moment I've got a slide that specifically relates to rural hospitals. But among rural hospitals the concern was that there would be specific services that the rural hospitals could not continue to afford to provide. And the two areas of service that came up most frequently were emergency services and radiology services. By no means was that a consistent reply but there certainly were some hospitals that were indicating that that was an issue.

As we've said, I think the biggest concern is that there's a great many unknowns remaining because the system is so new, and so there is just some fear of the unknown that we were able to identify.

There certainly are some positive impacts, in terms of quality and access. The inpatient list, while it is a problem, is also certainly a positive impact. Copayment improvements are a positive impact for the majority of hospitals, it's just that they affect some negatively.

Certainly, there is a dramatic improvement in

diagnosis and procedure coding among the hospitals, because that's required for payment. And that will allow hospitals to both improve their own utilization management systems on outpatient services, as well as others being able to understand outpatient services a great deal better.

MR. HACKBARTH: Can I ask a question about the inpatient list? What I hear you saying is that there are services that previously Medicare would pay for on an outpatient basis, but now they're paid for only on an inpatient basis?

DR. MILLER: That's correct.

MR. HACKBARTH: Could you give some examples of those services?

DR. MILLER: Specific examples? I don't think I can. I'd have to look them up.

MS. KARR: I think that's an overarching theme. A lot of the interviewees spoke in great generalities and said this is an issue, but very few specifics about these particular services or this particular procedure, in particular, is going to be affected.

DR. MILLER: I would say part of the issue is that the OPPS does not include payment for observation. As a result, there is certainly an understanding that some services require observation. Those are the services that are more likely to be included in the inpatient list. The inpatient list is not that long, but nevertheless, there are some services that were previously paid for on an outpatient basis.

MS. RAPHAEL: But you also said that was a positive. Could you explain?

DR. MILLER: Yes. It's positive in the sense that if, in fact, the judgment is correct that those are services where the patient would be better off on the inpatient setting, then certainly there would be more continuity of care, longer care available to the patient. So it could certainly be seen as positive. And I think anybody who was involved in the system prior to its implementation would have assumed that that was a positive impact. It's just that we have created protocols, hospitals have created protocols and methods of care that have left those services

-- at least in the minds of the people that we spoke to. They feel as though those services continue to be best provided on an outpatient basis.

DR. WILENSKY: It's similar to the move to not pay for some services any longer in the physician's office that were judged to be more appropriately provided in an outpatient setting attached to the hospital, but with the hospital services available. So we obviously can, at some point, assess whether there is some consensus judgment about the wisdom of those changes. But there were some attempts to limit payment from what had been lower intensity level places because of the feeling that they were not provided with sufficient safety and backup services.

So it went both ways, from the outpatient to the inpatient, and from the physician's office -- particularly in a number of places where there was a move to not encourage things in the physician's office, to get them back into the hospital clinic setting, so that they would have the services of the hospital available if there was a problem.

DR. MILLER: It's probably worth noting that this particular concern was the most frequently mentioned by the interviewees. So that across the board, even though there were several other issues that arose, this one arose most frequently.

DR. NELSON: Dr. Miller, did you get the sense in your interviews then that what was happening was a different protocol or a different standard for handling Medicare patients, as opposed to age 64 patients that emerged as a product of this?

DR. MILLER: Yes.

DR. NELSON: Does your gut tell you that Medicare patients are receiving better care or worse care, if there's a different standard?

DR. MILLER: I think that would be very hard to say. I think the issue really is that it's based on the specific patient. Certainly, if the service is provided on an outpatient basis to somebody in the ages of 60 to 64, there's probably not much difference for the patients aged 65 to 69. But that's not to say that the patient over age

1 70 or over age 75 wouldn't best receive that service on an
2 inpatient basis.
3 I'm not trying to dodge the question. I think it
4 is just very difficult to answer.
5 MR. DeBUSK: These are APC codes that were
6 established codes. Now some of these have gone within the
7 hospital and would then come under the DRG coding system,
8 right?
9 DR. MILLER: Yes, CPT codes that are not being
10 classified yet.
11 On the financial impacts, we've talked about them
12 and I don't think there's any great surprise there. One of
13 the concerns that we haven't spoke -- certainly there are
14 significant implementation costs that the hospitals have
15 been concerned about. They are concerned about decreased
16 reimbursement. One point that we heard consistently is that
17 the rate of decrease in outpatient payment that the
18 hospitals are either anticipating or experiencing at this
19 point is considerably greater than HCFA's projection.
20 The range that we were told was a reduction of

1 from 3 to 25 percent. Of course, this is not by any means
2 empirically determined and is just based on the input of the
3 specific people that we spoke to. But that's considerably
4 greater than HCFA's determination. And that was pretty
5 consistent, as well. It wasn't as though that was the
6 report of one or two hospitals. That was pretty much across
7 the interviewees.
8 MR. DeBUSK: Why?
9 DR. MILLER: One speculation as to why is because,
10 it being as early as it is in the implementation of the
11 system, the process of submitting and getting paid for
12 claims is not as straightforward as hopefully it will be in
13 the future. So that when the hospital looks at how much
14 it's getting paid now, there can be a great many claims that
15 are going back and forth that are pending or for which the
16 full payment hasn't been received.
17 MR. HACKBARTH: So it's a cash flow --
18 DR. MILLER: That is one reason. I also think
19 that the hospitals that have done -- and among the people
20 that we spoke to, we spoke to consultants who had worked

with hospitals to calculate what the impact would be. And we ourselves have done a good bit of that work for hospitals. And we've consistently, and they've consistently measured a greater impact than the HCFA projection. But in terms of why, it's very difficult to say.

MR. DeBUSK: I think the way the law has changed is that the first diagnosis they pay 100 percent, and thereafter 50 percent.

DR. MILLER: There are several procedures for which the first procedure the payment is at 100 percent. If an additional procedure is performed during that same visit, not all of them but certainly a significant number of procedures are subject to a reduction of 50 percent, and any subsequent procedure at 50 percent.

But number one, that doesn't occur that frequently. Number two, that has been the policy within the ASC payment system and it occurs -- where more than one procedure is performed, it occurs in a fairly limited number of cases. Certainly fewer than 10 percent of cases for ambulatory surgery. And for most other procedures it occurs

1 far less frequently.

2 So I don't know that that is that big an issue,

3 but it is an issue.

4 MR. HACKBARTH: Does the shortfall suggest that

5 the hold harmless system isn't working as anticipated?

6 DR. MILLER: Once again, that may be an issue of

7 timing. No, because the hold harmless component relates to

8 specific facilities. Certainly in the case of rural

9 hospitals, they are being held harmless. And some of the

10 concerns that we are hearing relate to what will happen when

11 that transitional period is eliminated and some of the

12 concerns relate to the fact that there's just a lag in

13 payment, and it may very well just be a cash flow issue. I

14 think in those situations it is just a cash flow issue.

15 DR. WILENSKY: Don't you think it's also maybe a

16 question of whether the perceptions are actually reflecting

17 reality? I think people have to be a little careful about

18 accepting perceptions of people very early in the system.

19 It may well be that some of these effects will turn out to

20 be true, but we're not looking at audited financial

statements. We're looking at where people think they're going to end up after they do a year in settlement in a system that's just starting.

So I think to go back to Jack's point, probably if we were -- you could imagine doing a pre-PPS baseline study and then doing a study two or three years later, a significant reason for doing the study is that the BBA directed us to do such a study. We can think about whether it would be appropriate to redo some aspect of all of this later when there's been a shake out, whatever occurs in terms of getting billing procedures and you know where you are.

But I think you have to be a little cautious on assuming that perceptions early in the system of financial impact actually reflect the financial impact.

DR. ROWE: I agree. My concern about the timing is only partly a concern with respect to the validity of the data. The other concern is how the findings will be used because people who don't like this system are going to jump on these early findings and run around town with them in the

press and on the Hill and everywhere else saying see, we told you, when in fact they may not reflect the system at steady state.

DR. WILENSKY: And in fact probably won't.

DR. ROWE: So that's my concern, is that you're almost better off without the data. I was accused yesterday of operating in a data-free environment, so I just want to continue to build my reputation with respect to this.

But you're almost better off without it, if it's not valid or not steady state, given the environment that we're in.

DR. WILENSKY: Almost better off unless it's a congressionally requested study. You can try to be as clear as you can about this is perceptions and not financial.

DR. ROWE: It should probably say preliminary report or something like that.

DR. MILLER: In fact, the study is titled the potential impact and we're trying very hard to report that these are in fact perceptions. And it is speculation at this point. There's a little bit of information that's

coming out of it this early. But for the most part, this is the expectation rather than the reality.

I just have a couple of more comments that I would like to finish, and specifically as it relates to rural hospitals. Some of these we've already talked about. One of the things that we found was that, in addition to the rural hospitals being protected in the short term, they are very concerned about what will happen when the period of protection ends.

A second point is that there's a great deal of attention being focused by a large number of rural hospitals, more than ever before, on applying for and becoming critical access hospitals, which will provide them with some freedom from some of the concerns that they have.

The concerns about quality and access really relate to the elimination of services and the services again that were reported most frequently by rural hospitals were concerns about emergency departments and radiology services that could not be continued by the hospital because the payment levels weren't sufficient.

Now this clearly is a perception. We did not identify any hospitals where these services had been discontinued or where there was a firm plan to discontinue them, but these were issues that were raised.

We identified the issue of high copayments. One other thing about rural hospitals that is important is that, like the DRG system, the APC system is an averaging system, which means that when a hospital provides a service and submits a claim sometimes the APC payment will be higher than the resources that require to provide care to the patient. And sometimes it will be lower.

The implication that we heard consistently was that rural hospitals having much lower volumes were at far greater risk because of this averaging process and the fact that they could conceivably have far more cases that were paid at a lower level and wouldn't have the opportunity to average them with those that were paid at the higher level. So that was again a speculative concern, but nevertheless a concern that the hospitals had.

Finally, a component of our work was to identify a

method or indicators to measure quality and access as they change under the system, so that there is an empirical basis for determining whether or not these changes are occurring.

This turns out to be a very difficult task and a challenging task for MedPAC, as well as for us within the constraints of our work. The reason it's challenging is because very little attention has been paid so far to measuring and collecting data on outpatient services. The primary data that's available is on inpatient services and you can look at inpatient services at great length thanks to the hospital discharge data systems that exist across the country.

There are very few comparable outpatient systems. There are some, but they are very few and they are based in specific states. So that if you wanted to look at New York or Maryland, for example, you can look at ambulatory surgery at length. But you couldn't necessarily do that in very many other places.

The data sources that would ordinarily be available also have a limitation in that they focus on a

single provider. One of the concerns here would be that services are being shifted from outpatient departments to physician offices. There are very few data systems that would allow you to pick that up because as few data systems as there are in outpatient services, there are even fewer on physician services. So it becomes very difficult to do that.

One more point, there are some surveys that are available. There is the Medicare beneficiary survey and there are other surveys that look at services provided across the board. But the problem with surveys is they don't allow you to examine the data in detail because they're typically based on a national sample, so you can't break it down by geography. And frequently, you can't break it down by type of provider. So that if you wanted to look at rural hospitals or you wanted to look at academic medical centers those surveys would not be a very fruitful source of information.

So all of this says that it's quite difficult to come up with recommendations for monitoring, although our

1 approach has been to focus on two questions. The first
2 question being what is it that MedPAC would be most
3 interested in monitoring? What specific aspects of services
4 are most important? And the second is given that we can
5 narrow it down to those specific indicators that would be
6 most important to look at, what are the sources of
7 information available to them? Or what source of
8 information can be created?
9 DR. NEWHOUSE: Help me with the following problem.
10 It seems to me it doesn't help to talk about access to
11 outpatient hospital services except in the context of
12 substitute sites, such as offices, rural health clinics,
13 ASCs, inpatient services. So any plan to monitor or study
14 this downstream seems to me has to be holistic.
15 DR. MILLER: I should have said that. It needs to
16 focus on the service and not necessarily the provider. It's
17 more important to note that the service is being provided in
18 some setting.
19 DR. NEWHOUSE: Exactly, and my druthers would be
20 to say that if for no other reason than to forestall a

mandate to study access to hospital outpatient services.

DR. MILLER: In fact that is the direction that we're taking.

DR. WILENSKY: Any other questions?

DR. WAKEFIELD: Just a comment. I appreciated your comment I think you were making about the difficulty in collecting data and we heard from somebody in the audience at the end of yesterday's session who spoke about the MCBS and its really problematic undersampling, especially of rural Medicare beneficiaries. I think that just -- for another discussion at another time -- speaks to the need to really try and get a handle on ways that HCFA and others can more frequently oversample or use other sampling techniques to try and cull out with a little bit more accuracy a better reflection because it is such a difficult sample to get at, given the variation across rural areas.

DR. NEWHOUSE: Mary, does it undersample rural nationally or is the issue that because of the cluster sampling it's not representative of a specific UIC code?

DR. WAKEFIELD: I thought the answer to that question was both, but I'd have to defer to the person who was speaking to it last night. You could ask her, I think she's here.

If I could just finish that question. To that question, I was just wondering out of curiosity, on the hospitals, where you list on page three the types of organizations that you sampled, could you tell me just a little bit more about the 53 hospitals who you included here? A little bit of a sense of what they look like?

MS. KARR: Actually there were 25 hospitals.

DR. WAKEFIELD: So 53 contacted and 25 who participated. So on those 25, a little bit more about what they looked like?

MS. KARR: They were geographically dispersed. They were handpicked, though, as hospitals that had looked at APCs or had some consideration before. Some of them were in inner-cities. I can tell you their location in just a minute.

I think some of the inner-city hospitals were in

1 Dallas and New York City, Little Rock, Arkansas,
2 geographically dispersed. But again, it wasn't a national
3 sample.
4 DR. WAKEFIELD: Some under 50 bed and over 50 bed
5 rurals in both categories?
6 MS. KARR: Yes. Actually, average bed size for
7 the inner-city hospitals was pretty large, 974. For rural
8 hospitals, we looked at eight rural hospitals in Ohio,
9 Mississippi, California, Vermont, Tennessee, Idaho,
10 Pennsylvania, and Maine. The average bed size there
11 actually was fairly large for rural hospitals, was 144.
12 Suburban hospitals in New York, Illinois,
13 California, Arkansas and New Jersey, average bed size 457.
14 Academic medical centers in New York, Michigan and Missouri
15 average bed size 658.
16 DR. ROWE: One of the questions that came up when
17 we were discussing these proposed changes over the last
18 couple years had to do with the different patient
19 populations that are seen in different sites for outpatient
20 care. One of the concerns that we had was that the hospital

outpatient units might disproportionately have a population that was say disproportionately enriched with frail elders, people who weren't really able to just go to a doctor's office but would be in a hospital outpatient clinic, people with more comorbidities, perhaps people with dementia, people who needed more supports to get around, et cetera, and just needed more resources that would be more available or might even be patient populations that were less sought after by some providers and therefore wound up in the clinic, if you will.

Certainly, in geriatric medicine there aren't many geriatricians practicing in the community. Where there are geriatricians, and there aren't that many of them, they're usually associated with hospitals and outpatient clinics.

So one of the considerations, I think, from that would be that as you go forward, or as you look at the data, if you can, it's not just the patient population. But if you could stratify in some way by advanced age or some measure of frailty or a number of diagnoses or some diagnostic marker such as Alzheimer's disease that might be

the primary or secondary diagnosis, I think that my concern with respect to access and quality would be with respect to particularly that patient population.

So if you could look at that in some way, I think that might be informative.

DR. WILENSKY: Other comments or questions?

DR. REISCHAUER: Just to follow up on what Joe was saying. As you think about wanting to analyze the impact of this change in policy, from an individual standpoint you're worried about the quality and quantity of services that are used. But you also care about where those are in a geographic sense as opposed to just is it in an outpatient or a physician's office? Are people having to travel another 50 miles to get these services?

And you also are interested in issues of institutional survivability and the evolution of institutions over time. If the outpatient departments begin to shrink, it might say something about the ability to attract certain kinds of health care professionals to certain rural environments. Or it might say something about

the long run viability of these institutions which you won't pick up in the first five years, but 10 years later you'll find that this change has in fact had a larger impact on the structure of medical care providers across the country.

DR. WILENSKY: Further comments?

Thank you.

Chantal, we'll have you do your presentation and then we'll review some of the recommendations that we were going to revisit this morning. But I think it makes sense to continue on with your section. Thank you.

DR. WORZALA: Before I start with my own presentation I just want to clarify one point. The study that was just described was not, in fact, mandated congressionally. The reason we did it early rather than late was there was so much discussion about how terrible this payment system was going to be, that we wanted to have some notion of an early warning system. We never thought that we were getting definitive results about the implications of the new payment system.

And hopefully, we will do a repetition of this, or

1 someone will continue the work in the future.

2 On to the next presentation, I'm here to discuss

3 the appropriateness of the outpatient PPS for rural

4 hospitals. This analysis, however, does respond to a

5 congressional mandate and it will be a chapter in the June

6 report. The policy question before us is the following: do

7 rural hospitals face special circumstances that make the

8 outpatient PPS inappropriate for them?

9 The reasoning behind asking this question is that

10 if PPS pays hospitals based on average costs and if rural

11 hospitals face circumstances beyond their control that

12 result in systematically higher costs, then they may need

13 special treatment under the payment system.

14 You'll recall that we discussed this question in

15 March, and the next slide is a reminder of what we covered

16 then. I don't intend to address any of these points in

17 detail here, but of course I'm happy to answer your

18 questions on them.

19 I presented you with findings that show some

20 evidence of special circumstances for rural hospitals. For

1 example, rural hospitals have a greater reliance on Medicare
2 as a share of revenue, and within Medicare on outpatient
3 services. This does lead to greater exposure to the
4 financial risks that are inherent in a prospective payment
5 system.
6 They also have limited administrative capacity and
7 financial reserves hampering their adaptation to a new
8 payment system. And finally, many rural hospitals are low
9 volume, leading to higher unit costs and less ability to
10 spread risk across services.
11 However, there are serious limitations to the
12 evidence that we can gather so far, including lack of real
13 experience operating under the new payment system and also
14 data issues with both costs and claims.
15 We noted that rural hospitals with 100 or fewer
16 beds benefit from a hold harmless provision that limits
17 their losses under the PPS through 2003. This policy does
18 cover more than 80 percent of all rural hospitals.
19 Finally, in March, we discussed future policy
20 options including maintaining the current policy,

establishing a separate conversion factor, implementing a low volume adjustment, extending the hold harmless provision, and returning to cost-based payment.

The one piece of new information that I have for you today are the results of a cost function analysis which we undertook to explain the observed differences in unit costs among hospital types, and also to examine the cost volume relationship.

I want to begin with the caveats. First, this is fairly old data which suffers from the same data reliability and validity issues we have discussed previously. In particular, there has been documented undercoding of these claims historically, which understand volume, which could be problematic in an analysis such as this. Also, there are difficulties matching the cost data to the claims.

Finally, we only have one year of data, which lowers our confidence in the findings, particularly regarding the low volume hospitals due to annual variability, both in costs and volumes.

Nevertheless, we went ahead and did the analysis,

and I'll present the results from a model that includes only variables that affect payment. The results from a general model, that included more hospital and market characteristics did find a similar volume/cost relationship.

DR. ROWE: Chantal, would you add amongst the caveats the fact that the data are five years old and that perhaps things have changed?

DR. WORZALA: Yes. That was actually my first caveat.

DR. ROWE: More recent data were not available?

DR. WORZALA: We could have invested considerable resources in developing more current data, but given the issues with coding of claims and matching cost reports to outpatient claims data, we didn't think that the data would be any more reliable in a later year. So we thought we would put that off until we had real data from under the outpatient PPS. This is the data that HCFA put together to create the payment system.

The model explains variation across hospitals and unit costs from Medicare outpatient services. Those costs

are adjusted for service mix and differences in input prices using the wage index.

The independent variables were cubic expansion of an annual volume measure, which was the number of services, hold harmless status and critical access hospital status. Both the dependent variables and volume variables were in log form.

The next graph illustrates the volume cost relationship at low volumes. I want to be clear that this is a truncated graph and one of the issues here is that volumes range from we did have some hospitals under 100 services annually, which I decided to take out of the sample. And they went as high as 500,000. So this is a remarkable range and what I'm reporting for you are those less than 10,000 services.

The X axis on this graph is annual volume as number of services, and the Y axis shows the predicted adjusted unit cost relative to the mean adjusted unit costs for all hospitals. So this can be thought of as a percentage above or below the mean unit cost.

You can see that the graph shows higher unit costs at lower volume levels, as we might expect. I do want to note that the values shown here on the Y axis do differ from those in your briefing papers, and the estimated differences are considerably higher in the corrected graph.

Hospitals reporting fewer than 2,000 services per year had adjusted unit costs at least 15 percent higher than the average. Approximately 10 percent of hospitals had volume of less than 2,000 services.

MR. HACKBARTH: What percentage of the rural hospitals would fall within this volume range? Is this the vast majority of them?

DR. WORZALA: Sixty percent, if you take the 7,000 services, which is where the curve meets the mean and then falls below it, about 60 percent of rural hospitals fall below that level.

MR. HACKBARTH: So considerable.

DR. WORZALA: So it definitely is tilted towards rural at the low ends. And it's 40 percent of all hospitals that fall below the 7,000 volume level.

We did find no statistically significant difference in adjusted unit costs for all urban hospitals, larger rural hospitals -- those with more than 100 beds -- and rural referral centers. They seem to exhibit the same relationship. And these hospitals are the reference group, which is the bottom line on the chart.

However, rural hospitals with 100 or fewer beds had unit costs that were 2 percent above those of the reference group at any volume level, and this is the middle line of the chart. These higher cost hospitals do benefit from the hold harmless provision.

And finally, critical access hospitals have unit costs that were 7 percent above the reference group at any volume level. This is the top line.

Given that these cost data pre-date the critical access program here there's actually a benefit to using 1996 data. It does show that the high cost hospitals have chosen to convert to critical access hospital status and they will be paid on the cost basis in that program.

I want to emphasize that we shouldn't attach any

1 importance to the 2 percent and the 7 percent, only to say
2 that the small rural hospitals are slightly more expensive
3 than the larger rural and the urban, and that the critical
4 access hospitals seem to be a fair amount more expensive
5 than the reference group.
6 So keeping in mind our caveats, the conclusion
7 that I would draw from this is first, that volume clearly is
8 an important factor, but there are other factors working for
9 the small rural hospitals and the critical access hospitals.
10 Second, it appears that the rural hospitals with
11 the highest costs did convert to critical access hospitals
12 and are now exempt from this payment system. The remaining
13 rural hospitals, the small rural hospitals, have unit costs
14 that are slightly higher than the urban and large rural
15 hospitals after accounting for volume. Again, those
16 hospitals do have a hold harmless protection at the moment.
17 So to summarize the evidence I presented in March
18 and the results of this analysis, I would make three points.
19 First, there is some evidence, I think, of systematically
20 higher costs and unique circumstances facing rural hospitals

and particularly the small rural hospitals. However, the evidence has serious limitations and we don't have any experience actually operating under the PPS. The cost data we have is old and suffers from other limitations. And finally, the existing hold harmless policy benefits those small rural hospitals that appear to be most vulnerable to the payment system.

So taken together, these points suggest a policy of what I call watchful waiting and I have drafted the following recommendation for you to consider. Do you want me to do the recommendation now, Gail?

DR. WILENSKY: Yes, why don't you just read it and then we'll open it for discussion.

DR. WORZALA: In the short term, no outpatient payment adjustments for rural hospitals are needed beyond the current hold-harmless provision. The Secretary should revisit the issue when better information on hospitals' experience with the payment system is available.

DR. NEWHOUSE: Chantal, I have two kinds of comments on the technical side for the cost function, and

then a comment on the draft recommendation or a question. First, I think there are really serious technical problems with trying to estimate a low volume adjustment. One of them, I agree with you that there's almost certainly some economies of scale. But if the conclusion of that is therefore we need to get to a low volume adjustment and we're actually going to write down how much more we're going to pay per unit of service based on volume, that's going to be really hard.

One of the things you pointed to, which is the year-to-year variability, and that's potentially estimable and fixable, although the current version of bias is toward showing economies of scale, as you've said. The other one, however, I think is really hard, that you didn't mention. That is I think the right way to do this has to be to take account of all the product lines of the hospital, not just a separate analysis of the outpatient department. Because the issue is how the hospital has allocated its joint costs across product lines.

So that actually gets to also the low volume

adjustment in the inpatient side. I think it's just a really hard problem. I think both of those low volume adjustments are hard. But I think the analysis ought to say that that conceptually is the right way to do it because the hospitals will be allocating their costs in different ways.

On the recommendation, I don't have any problem with the bottom line of the first sentence.

On the revisiting the issue when better information is available, what I wasn't clear about was what information was going to be available on the rural hospitals where the hold harmless provision was in effect. I mean, first of all, could one trust the data that were going to be submitted by them, given the fact that they were held harmless? In the same sense that the urbans were actually being paid on that basis?

Second, did you have in mind extrapolating from the urbans back to the rurals? And are there really enough urbans down at that small scale to do that? And then how did this play with the conversion to critical access?

I wasn't clear, I mean while it's kind of

motherhood and apple pie to say to revisit when better information is available, I guess it would be nice if we pointed to how we were going to learn something from this better information, a little more specific.

DR. WORZALA: I did try and point in that direction in some of the questions that I asked at the end of the chapter. In terms of data, the way that the payment system is operating, hospitals do operate under the PPS. They submit their claim, the claim is paid. The way the hold harmless policy works is that there is a determination made at the end of the year as to whether or not hospitals were paid as much under the PPS as they would have been paid under previous payment policy.

So we ought to be able to get data that tells us what they were paid for the PPS services and what they were paid as supplemental TOPS payments. So we can still extract their costs for the services, so that it would be the same data manipulation only we would have better coding to be able to map the costs to the claims and to know that volume has been counted accurately.

So in terms of constructing data, it would be the exact same data construction process and the hold harmless policy, in its implementation, should not get in the way of being able to tease that out.

DR. ROWE: Chantal, my question has to do with what I see as an ambiguity here. It may really not be a problem, but maybe you can help me with the economics of this.

It seems to me there are two issues. One is size of hospitals. You're defining this as less than 100 beds, which is kind of a measure of the capacity of the hospital. Then the rest of this has to do with volume.

It seems to me that there might be a mixture there. There might be small hospitals of 99 beds that are very busy and very full and are really using their capacity very much. The costs there might be significantly different than in a 99-bed hospital that has 10 patients on average in the census and very few visitors to the outpatient unit.

So by saying these are the small hospitals and this dataset represents them and this is how they behave, it

seems to me that it might be more informative to sort of say what is the relationship of cost per unit item in those hospitals that are operating at or near capacity or in a higher quintile, and those that are operating at the lower quintile.

I think it might be possible that the lower quintile ones are the ones we really are worried about and that we don't want them to disappear because it would be an access problem, et cetera. Maybe you can help me with that.

DR. WORZALA: It would be wonderful to have that kind of data, but I think there are two reasons to be concerned about what you've termed the lower quintile. One is that they may really be the only access around. Or they may be simply duplicate capacity that ought to close. That's very difficult to know which of those two things are there.

The reason we used 100 or fewer beds is because that is a payment provision, so those are the hospitals that are currently getting 100 percent of hold harmless payments from the system. And I think, in some ways, I found these

results reassuring in that the payment system does seem to distinguish between groups that are in fact different in their cost structures.

DR. ROWE: But you could take these hospitals and take the group that were between 50 and 100 beds, say, and then array them by the number of discharges per year, per bed or something. And then take one group of them that's up and one group of them that's down and look at this analysis. Would that be informative in any way?

DR. WORZALA: I think this is another issue that I've been struggling with and that needs more attention analytically, which is that why exactly are we using an inpatient capacity measure to may payment decisions for an outpatient payment system? I'm not sure, given the diversification that's happening in the hospitals away from inpatient services apparently, particularly in rural settings, I'm just not sure that using the inpatient measures makes that much sense. We clearly use them for reasons of history and for reasons of convenience. It's something that's very simple to measure.

But I guess I have a question of whether or not doing what you suggest would tell me anything about their utilization of their outpatient capacity, which is what we really care about.

DR. ROWE: That's a good point. With respect to this variable that's what we care about.

DR. WORZALA: And I'm not sure anybody knows a comparable measure of outpatient capacity. What would that be, FTU working on outpatient services? Volume? It's very hard to measure outpatient capacity, I think.

DR. WAKEFIELD: Just a couple of comments on text and then straight to the recommendation. There are a couple of places in the text, and I'll give you my written suggestions for you to consider Chantal, where it seems to me there's a -- I don't want to say confusion between the concept of inefficiency and higher costs due to low volume, but where it almost seems that we're suggesting that when we see high cost due to low volume, it would come almost right up to the line of labeling that as inefficiency. I'm not an economist, but it seems like we might almost be using those

concepts interchangeably.

I'll share my text with you and you can take a look at it, if you'd be so kind, on that front. Because I think we need to be really clear about that.

DR. WORZALA: It certainly wasn't my intention.

DR. WAKEFIELD: I didn't think so, but I just wanted to highlight that.

Second, I've got a question that probably Joe or Gail could answer this, or maybe you could, too, Chantal. And then I'm going to go to the recommendation. Is it likely that with outlier payments for outpatient PPS that they could conceivably have a more negative impact on rural hospitals in that outliers amounts are subtracted from those base payments. And to the extent that you may not see much in the way of outlier cases in rural hospitals that overall there could be a negative impact on rural hospitals given the extent to which they do it on outlier payments?

The reason I ask that question is because the issue of outlier payments is discussed on page five. So I just had a question.

DR. WILENSKY: It will lower the base, presumably it's lowering the base in an appropriate way to pick up the fact that you have these extreme cases and, to the extent that some rural hospitals will indeed have outliers, they would probably be the least able to cope with these outliers.

DR. NEWHOUSE: The thing about the inpatient side, I mean you could make the same argument on the inpatient side, but in the large urban hospitals where you get the outliers, that's where you're having the costs of these cases. And the pot of money, it's a question of how you send the pot of money around to different hospitals. And you're trying to send it to where the costs are.

DR. WAKEFIELD: Then your point, Gail, about those cases for very small hospitals where you do see one or two outliers, you're saying in that case that comes back in.

DR. WILENSKY: There's a reason outlier payments are really important when you have a system of averages. And to some extent you could say they're more important in small or low volume hospitals because you could more or less

1 incorporate the variation that you might see. That's a
2 somewhat extreme case but you are less likely of it being
3 able to tolerate random hits.
4 DR. WAKEFIELD: Thanks for that explanation.
5 With regard to the draft recommendation, I'm a
6 little bit concerned mostly about the first sentence in
7 terms of its wording, that in the short term no adjustments
8 for rurals are needed beyond the current hold harmless
9 provision.
10 Let me step back and comment directly on the
11 recommendation. The first sentence, I'm concerned about the
12 fact that there seemed to be some cash flow problems that
13 I've heard from rural hospitals specifically. There are
14 clearly some problems with changes in inpatient copay to
15 beneficiaries in rural areas. It's also a fallout of this
16 new system.
17 And I'm concerned that we've still got data
18 problems. My concerns aren't alleviated much by the earlier
19 presentation that preceded yours, that we're going to have
20 data that will have been collected, analyzed, and that HCFA

is able to react to, and that rural facilities will be able to comment on between now and when this hold harmless is lifted.

So I'm concerned about our saying that there are no outpatient payment adjustments for rural hospitals needed beyond the current hold harmless provision. I don't know that we know that to be the case. I don't think we know much, I guess is what I'm saying at this point in time.

DR. WILENSKY: Let me just try and make sure I'm clear about what you're saying. We clearly know what we know and in the short term we don't know very much about the outpatient PPS for rural or urban hospitals.

But my sense is either we have a recommendation that we make about what we think should be done with outpatient or we think that in the interim -- I mean, I'm assuming the short term is really this interim period -- is there a different recommendation that you would want to propose that we make for rural outpatient now, other than to say that for the next year-and-a-half, roughly the period in which we're covering because you have to get ready for

1 whatever you're going to -- next year we would have to be in
2 a position to say following 2003 here's what we want to have
3 happen.
4 So really the question is do you have a
5 recommendation that you want the commission to consider as
6 to what we propose now, between now and 2002?
7 DR. WAKEFIELD: Yes, I'm not sure we're giving the
8 hospitals themselves or HCFA adequate time to accumulate
9 information that's needed to understand the impact of this
10 PPS on small rural hospitals and then to react to that
11 information. So I guess what I'd be asking for at least a
12 transition after 2003. I'm just concerned that by 2003,
13 that hold harmless drops off sharply and those outpatient
14 facilities get what they get.
15 DR. NEWHOUSE: Let me suggest a change, what I
16 think has the same substance but may be a change in tone
17 that addresses your issue, which is something like, current
18 information is inadequate to suggest a change in the hold
19 harmless provision. Leaving open the possibility that
20 information may accumulate downstream that would suggest a

1 change. But we don't have any basis for doing anything at
2 the moment.
3 DR. WAKEFIELD: We don't.
4 DR. WILENSKY: And next year, we could presumably
5 make a recommendation in 2002 that when the period ends that
6 we transition rather than drop in one year. I'm not sure
7 that that's particularly a 2001 recommendation but we can
8 consider it.
9 MR. DeBUSK: Chantal addressed what I was
10 concerned with. I think the recommendation looks pretty
11 good the way it is. Until you collect some data, and if
12 you're being held harmless and we're running a prospective
13 payment system over the next several months prior to the
14 deadline, surely out of that -- and we have two years that
15 we can come up with just what the actual performance is. I
16 mean, you're going to have real data instead of '96 data.
17 Surely we can look at that and make a decision.
18 If these hospitals with the low -- I mean, it's a
19 volume issue. That's what it all comes down to. If there's
20 some provisions that's going to be needed to be made in

order to compensate these people more in the rural areas, looks like we could do that in the last year or so prior to the expiration of this period.

DR. WILENSKY: I think we'll be in a much better position a year from now to know whether we think -- what kind of a recommendation we ought to make rather than two years out. I'm not sure whether we'll have the information or not, and we certainly historically have recommended transitions, although I don't know whether this is the same magnitude of change that usually recommend a transition. But transitions have been a frequent recommendation of this and predecessor commissions, so there's certainly a lot of precedent for it.

MR. DeBUSK: There's a whole new coding system that went into law last year that's not even rolled out yet with the outpatient piece, and there's a new revenue stream, that's not even been addressed. I won't go into that today, but there's a lot of things to happen yet before --

DR. WILENSKY: There's clearly a lot we don't know.

DR. STOWERS: The only problem I had with the recommendation is the word beyond. Do we mean in addition to?

DR. NEWHOUSE: Yes.

DR. STOWERS: Because we very easily here could send the message to Congress that at the end of 2003 or whatever, that it shouldn't go beyond that.

DR. WILENSKY: No, that was not -- in addition to is clearer.

DR. STOWERS: So I would make that change.

DR. BRAUN: I had a little problem with the text on page 10, and because it changes the meaning a little bit I thought we needed to bring it up rather than just letting you know. It seems to me that the section under unique social role, that we're saying something that we don't ordinarily believe in. As a matter of public policy we may wish to pay more for services provided in rural hospitals, not only due to higher cost but because they serve other important functions that we're willing to subsidize through higher payments.

DR. WILENSKY: I think that's actually a good point. I think at the most we can say that it's been argued that. We as a commission have certainly not bought into that.

DR. BRAUN: But I think we could probably reword that so it sounds something like, as a matter of public policy we may wish to emphasize the need for adequate payment, and then in the latter part say, serve other important functions whose continuance we're willing to assure through higher payments. I think that would give the emphasis to the social role but won't say what we don't want to say.

DR. NEWHOUSE: This isn't the only place in this report that the social role comes up. I personally agree with Gail, that we should be agnostic as a commission on that.

DR. WILENSKY: I think we have very clearly indicated our concern that seniors be able to get access to affordable health care. If that means paying more, and low volume impact on cost suggests that it would mean paying

1 more for certain kinds of hospitals or cost-based systems
2 for critical access hospitals, et cetera, I think we're all
3 comfortable that that's what it will take to get -- if
4 that's what it takes to get seniors access to high quality
5 care, that that's something that we're comfortable
6 recommending.
7 I don't think that this commission has had that
8 discussion about whether we would be willing to recommend
9 higher payments so that economic development can occur in a
10 rural area, and I don't think that's the function for this
11 commission. So I think we ought to in general go through
12 the report to make sure that we are not seen as advocating
13 that position. Again, that's certainly a position that
14 other people have advocated but I don't think it's our --
15 DR. ROWE: It's interesting that yesterday much of
16 the discussion with respect to rural hospitals in the area
17 of payment had to do with margins; talking about inpatient
18 margins, total Medicare margins, total hospital margins.
19 This discussion is primarily about cost. It's not about
20 margins.

I wonder whether or not it might be appropriate or helpful to bring in at least the concept of margin. That is, if we're going to be thinking about making adjustments, it shouldn't be just based on a relationship of volume and cost, but as you were saying yesterday, getting the Medicare payments right. It might be interesting to look at that issue.

DR. WILENSKY: One of the difficulties, obviously, with this area is that there has been some high degree of skepticism as to whether or not -- Bob was, I gather, going to say the same thing -- it's true for inpatient, but the inpatient is such a big number with so much stuff in it, you get a little less worried. With the outpatient, since we have had strong suspicions that it has been the recipient of many charges over the years, because of the incentives that we set up, that looking at margins for the outpatient may tell you many things, but not clearly the financial health of the outpatient.

DR. REISCHAUER: Which is underscored by Chantal's Table 3 where all hospitals have negative outpatient

margins. It's sort of like, why do you want to be in this business at all? Are you really dumb?

DR. ROWE: Absolutely.

DR. WILENSKY: So I think at some point if we believe the numbers have a chance to work their way through so that you get back to a better distribution -- in principle you're absolutely right, that's a good idea. But when you have this small sector which has been, we believe, the recipient of lots of charges that are not outpatient, you really have funny numbers. So I just don't know that you end up feeling you want to make decisions based on these numbers. It truly is hard to believe that these are real.

DR. NEWHOUSE: It goes back to the point the hospital really isn't separable in the way that we're trying to treat it as separable.

DR. WILENSKY: Why don't we return now to the recommendation and think about some of the wording change, and the issue that Mary raised about whether this year we want to go further. There's at least a couple sense -- one is, are we as a commission comfortable saying that for right

now we are not recommending a change in terms of payment in addition to the hold harmless. That's the first question.

The second concept is, while we may find ourselves a year from now uncomfortable that we understand the effect on rural hospitals, or that we may want to make a recommendation for transition as happened late in the game with regard to physician payment when we were getting ready to go to the practice expense and thinking about transitions, or whether you think it's important to make that statement now.

And then any other wording change. Ray had suggested the term, in addition, rather than beyond, to clarify and I think that makes it clearer what we mean. So the first is, are people comfortable with that first statement with that change?

Okay. I don't have a problem with the second statement. I think the real question at a substantive level is, is that okay? Then the additional question is, do we want to make an additional recommendation at this point or do we want to revisit this in a year? Because I think we

definitely need to consider the issues of what we know a year from now and what that leads us to recommend as they get ready to hit that 2003 transition.

DR. STOWERS: My only question is whether, or maybe we're not wanting to come right out and say that we think the hold harmless ought to continue until there is adequate data available to show that we will not have an access problem, or are we just inferring here that we're going to continue over the next couple of years before it expires? I just think maybe Congress is waiting for a message, should we extend this thing further, should we cut it off?

DR. WILENSKY: I think that's really the reason for the second question. To be perfectly honest, saying that does not send exactly the right signal about getting more information. So I think there is a problem. If you say, we're going to continue hold harmless until we are sure we have the data to suggest to go otherwise, you don't -- I mean, what we'd like to do is have enough information we feel comfortable.

Now I think it is certainly consistent with past recommendations. A year from now we will say, we ought to start transitioning unless we know something that we don't know now. I think that's certainly a very consistent recommendation. A year from now we might decide we really don't know enough and that an additional year is appropriate. I just get a little nervous about that we'll--

DR. STOWERS: I'm okay with that.

DR. REISCHAUER: I think also we should hold open the option that if we speak on this in the future we might be speaking in a very different way. What Chantal's information suggests is that urban hospitals with low volume of services have higher costs as well, and you might want to have a volume adjustment for all kinds of hospitals rather than just these less than 100 bed hospitals in rural areas.

DR. WILENSKY: Or not.

DR. NEWHOUSE: Or not, say if there's a hospital across the street.

DR. REISCHAUER: Or not for have it anybody, right. But what I'm saying is there's a lot of different

1 dimensions we'd want to look at.

2 DR. WILENSKY: Yes. So I would say, and in the

3 text it's certainly appropriate to indicate that there are a

4 lot of unknowns and we're concerned about it, and issues of

5 transitions are appropriate concerns, issues of whether or

6 not there's a need for a low volume adjustment for hospitals

7 with under 100 beds and that are serving a special function

8 is an issue that ought to be taken up when we have more

9 information. But to leave that door open I think at this

10 point, that would be my preference.

11 DR. WAKEFIELD: I agree with you, Gail, I think

12 that's fine and a good discussion of the framing in the

13 narrative that accompanies that. And low volume related to

14 isolated providers, getting at Joe's point. We're not

15 interested in erecting a barrier that's going to protect

16 everybody everywhere.

17 So I think to the extent we can reflect those

18 notions in the text that accompanies this, but fundamentally

19 saying, we just don't know enough right now, we don't know

20 enough to say that in 2003 this ought to be ended or it

ought to be continued. But people have got to pay attention to this. It seems to me if that's the tone, that would be great.

DR. WILENSKY: Yes, and especially in isolated.

Let's go down the recommendation. All those voting yes?

All those voting no?

All those not voting?

Thank you, Chantal.

MR. HACKBARTH: Could I just go back to the discussion we just had about margins and just help me think this through? We're saying that because of cost allocation in the past that the outpatient negative margin is probably not an accurate reflection of actual performance. I guess it also follows from that, however, that the inpatient margins are overstated, but given the relative size, the effect on the inpatient would be smaller.

But if we're talking about rural hospitals where the outpatient is a bigger proportion, the distortion on the inpatient margins would be a more significant issue. If in

fact they've been over-allocating cost to the outpatient side, inflating the inpatient margins, and the outpatient is a larger share of their business, that means the overstatement of their inpatient margins is more of an issue.

DR. NEWHOUSE: But remember, a number of those hospitals have elements of cost reimbursement, so they don't have the incentive to allocate in the same way.

DR. WILENSKY: It's just been so messy. The problem is, if we were comfortable that we knew what adjustments to make --

DR. ROWE: It urges looking at, if at all, at the overall Medicare margins.

DR. WILENSKY: Yes, absolutely.

DR. ROWE: Then you're not trying to chase the allocation --

DR. NEWHOUSE: That's my point.

DR. ROWE: That's the one piece that wasn't on those slides. We got inpatient Medicare margin, and overall hospital margin, but not overall Medicare margin.

DR. WILENSKY: I agree, and I think that in continuing to look at the issue, the total Medicare margin is at least as important as the total margin.

DR. ROWE: That's going to be more helpful in follow up, because what's going to happen in response to these policy changes in the outpatient PPS rather than cost based, whatever, is presumably they're going to stop over-allocating a lot of this stuff to the outpatient, driving up the outpatient cost base, and that shift would screw up the data except that if you continue to look at overall Medicare margins.

DR. WILENSKY: Murray has reminded me that we do get into an additional data problem because we tend to have inpatient Medicare and total margins first, and mostly Medicare or the total Medicare margin comes in somewhat second timewise. But you're absolutely right, and I think we have to be careful when we're talking about appropriate Medicare policy. I believe, and I think it's been consistent with the position of the Commission that we want to make sure Medicare is doing the right thing.

1 Now to the extent that we are having a little help
2 or a little harm from the private sector, it's not that we
3 should completely ignore it, because completely ignoring it
4 could mean access problems for the seniors, and that's an
5 issue. But we also have said we don't really want to get in
6 the business of either making up for bad decisions that
7 hospitals make in the private sector, or necessarily
8 penalizing hospitals because of some favorable conditions
9 they have with the private sector.
10 So I think it's fair to say, total margins are
11 relevant because total margins have something to say about
12 access. Medicare may be doing its share, but if the
13 hospital is going down the tubes that's going to -- if there
14 aren't other hospitals around, that will impact access for
15 seniors, so we can't ignore it.
16 But I think our primary focus ought to be on the
17 Medicare margin and the total margin. It maybe either to
18 have less -- if we ever get to a steady state, that the
19 inpatient-outpatient issue becomes less important. But as
20 long as payments are geared to inpatient-outpatient,

1 obviously they'll still have their own importance.

2 DR. ROWE: Can we address this lag or latency with

3 respect to the data? Is there a way to get the outpatient

4 data more promptly so we have the total margins?

5 DR. WILENSKY: I can't speak to -- that's

6 definitely beyond my pay grade.

7 DR. ROSS: I can't speak to the specifics but

8 that's been a continuing battle of all the things, relying

9 on different data sources. We're trying to get the early

10 indicators on the total margin data from our hospital

11 indicator survey that we sponsor with HCFA, and then

12 bringing in the cost reports, and then doing the

13 construction of bringing in the other services.

14 DR. WILENSKY: At some point this new AHA dataset

15 I thought was supposed to make many of these issues more

16 tolerable, but I gather not? Not yet.

17 MR. ASHBY: Let me just comment on that. The

18 inpatient margin, the outpatient margin, the total Medicare

19 and the total margin are all on the same schedule, about a

20 two-year lag. But we do have our separate survey that we

have cosponsored with HCFA that gives us a total margin on a very short turnaround.

DR. ROWE: For Medicare or total?

MR. ASHBY: No, total, grand total margin, on less than a six-month turnaround, which I think puts us in a really terrific situation to monitor the overall financial health of the industry. But beyond that, all of the margins are on the same schedule and we have that unfortunate roughly two-year lag.

DR. NEWHOUSE: You don't want to get carried away with the be-all and end-all of Medicare. That margin reflects how the hospital has accounted for allocating its cost between payers and among payers, and it reflects its payer mix.

DR. ROWE: That's why you need both, Medicare and total margins.

DR. WILENSKY: You weren't arguing against though. You were saying --

DR. NEWHOUSE: That's right. I agree with this, we do need them.

DR. ROWE: I was arguing for the Medicare total margin to get around this cost allocation, inpatient-outpatient problem.

DR. WILENSKY: I think we would be better informed to have a column that says total Medicare margin, or the closest approximation to the total Medicare that we can get.

MR. ASHBY: If we're talking about doing that now for the June report --

DR. WILENSKY: No, we're obviously not. We understand. We're not talking about it now for the June report.

MR. ASHBY: Because there's a slight difference in getting that total Medicare margin. It takes a special run from HCFA.

DR. WILENSKY: We felt like we knew enough about what the total Medicare numbers were looking like that we could mentally put the column out there. But in the future it would be helpful to actually be looking at the difference between the inpatient or outpatient Medicare, the total Medicare, and the total margins so that we could see both

1 Medicare's impact and the financial health of the hospital
2 at the same time. Especially because it turns out that it's
3 very different in general in urban versus rural, or
4 especially large urban versus rural in terms of who's
5 playing what cross-subsidizing role.
6 DR. WAKEFIELD: And how much work rural hospitals,
7 for example, do in the outpatient setting site.
8 DR. WILENSKY: And the different mix; different
9 mix between inpatient and outpatient, and where the relative
10 margins are high between Medicare and the private payer.
11 That's just so different that it makes it hard to not have
12 that.
13 Why don't we revisit our --
14 DR. ROSS: Labor share, home care data, and the
15 buy-in.
16 DR. WILENSKY: Who has the wording? We have three
17 recommendations we wanted to revisit.
18 MR. PETTENGILL: Except for the word carefully,
19 this is the recommendation you approved yesterday. This is
20 the proposed alternative.

DR. WILENSKY: Do you want to flip up again where we started from? This was looking at -- what we had approved yesterday minus the carefully was, examining the costs included in the labor share to ensure that each labor share only includes costs for resources purchased in the local markets. The suggested revision is what we just had distributed.

MR. PETTENGILL: This puts the emphasis on whether it's local or national rather than --

DR. WILENSKY: Okay. Voting for?

Voting again?

Not voting?

Done. Thank you.

There were two other revised recommendations, one on home health and one on access.

MS. ZAWISTOWICH: I think the quality one we resolved yesterday.

DR. WILENSKY: Okay. There was an access revision somebody was doing?

MS. MUTTI: This follows up from last night's

discussion on the access chapter. We just changed the wording to --

DR. WILENSKY: Excuse me. Glenn, have you had a chance to see the revision that we just --

MR. HACKBARTH: Yes.

DR. WILENSKY: Go ahead.

MS. MUTTI: This one I didn't hand out to you; it's just up on the screen there. It's just reflecting that we're identifying strategies to increase beneficiaries participation and trying to make it clear that it's government programs that cover premiums --

DR. WILENSKY: I think that's fine.

DR. NEWHOUSE: Do we want to specifically say QMB, SLIMB? I mean, government programs could be read to include state government programs. I don't know that we mean to include that. Are there other federal programs beyond QMB, SLIMB?

DR. REISCHAUER: Federal programs?

DR. WILENSKY: QMB is federal/state, isn't it?

DR. NEWHOUSE: Are there other programs than QMB,

SLIMB that we have in mind?

MS. MUTTI: Do you want to include dual eligibles?

DR. NEWHOUSE: If there aren't, it seems like that's what we ought to say.

MS. NEWPORT: Yesterday, the clarification, the question I asked was if this included Medigap, Med supp programs, and the answer was no.

DR. WILENSKY: That's a different issue. That's not encouraging them. These are encouraging people who --

DR. REISCHAUER: This is dual eligibles, QMB, SLIMB.

DR. WILENSKY: I think in the recommendation we should leave it that way, and in the paragraph following indicate, these government programs include Medicaid, QMB, SLIMB --

MS. MUTTI: And the QIs. Do the full range.

DR. WILENSKY: There's something after SLIMB that's even more limited.

MS. MUTTI: For home health.

DR. WILENSKY: List the various government, but I

1 don't think we need to put it in the recommendation, just to
2 have the paragraph following it.
3 All voting yes?
4 All voting no?
5 All not voting?
6 Thank you.
7 MS. BEE: This recommendation is intended to
8 address the data needs we identified in our earlier
9 discussion of whether or not to exempt rural home health.
10 This is new language.
11 This recommendation reads, the Secretary should
12 create a pool of home health providers for special study, to
13 evaluate as soon as possible the rural impact of the PPS, to
14 evaluate costs that may affect the adequacy of PPS payment,
15 and to find ways to improve all cost reports.
16 In the text to support this we would add, the pool
17 should include more rural providers than the pool used to
18 build the PPS. We want to investigate the effects of travel
19 and low volume, give special attention to isolated rural
20 areas, and investigate differences in patterns of care,

assess cost report burden issues, incentives, and the need for clarification.

DR. NEWHOUSE: In the discussion did we mean to limit this pool to rural home health agencies?

MS. BEE: No.

DR. WILENSKY: I could personally do without the, as soon as possible phrase, since I think that's somewhat gratuitous. Other than that I think the wording is fine.

DR. WAKEFIELD: You ticked what you were willing to put in, what you were thinking in the narrative. Will you also make some passing reference to isolated low volume?

MS. BEE: Okay.

DR. WILENSKY: In the discussion.

DR. NEWHOUSE: In those priorities that you laid out, did we come down on clarifying what they were supposed to report? That seemed to me to be important.

MS. BEE: Yes.

DR. WILENSKY: Any other comments?

All voting yes?

All voting no?

All not voting?

MR. HACKBARTH: Was there a vote on the revised labor share?

DR. WILENSKY: Yes.

MR. HACKBARTH: Could you show me as voting yes?

DR. WILENSKY: David?

MR. GLASS: Good morning. Now for a totally different topic. This is bringing Medicare+Choice to rural America or not. There are no recommendations in this chapter, and I think we had substantial agreement on the paper from the last meeting, but we want to get the commissioners reaction to the latest draft to make sure that we reflect the Commission's position clearly. I'm going to very briefly run through the main points in the paper.

I'll start with the March recommendation on M+C just so we get that context. In March we said, make M+C payments substantially equal to risk-adjusted fee-for-service payments. This implies that this would prevent market distortion and would imply there are no more floor payments.

1 We also wanted to investigate sources of fee-for-
2 service variation. It's appearing the use rates may not be
3 a source of wide variation urban to rural but rather in
4 specific local markets. Figuring out what variation there
5 is might suggest changes in payment policies for fee-for-
6 service and M+C that would allow some new options that we
7 haven't considered yet.
8 Finally, we recommended to enlarge payment areas
9 to produce reliable estimates.
10 The problem definition. Again, Congress looked
11 around their constituents and they saw that urban had lots
12 of Medicare managed care plans accompanied by extra
13 benefits, and they didn't have those in rural areas and this
14 was perceived as an inequity in benefits. Congress'
15 solution was bringing M+C plans to rural areas and assumed
16 that they would bring along those healthy benefits with
17 them. But in fact few M+C managed care plans have moved to
18 rural areas, few extra benefits have shown up, and there's
19 been very little enrollment in rural areas.
20 We suggested that one of the problems, the basic

1 problem is what the markets are like. Market reality is
2 that many rural areas are not conducive to managed care.
3 It's difficult to form networks and negotiate discounts
4 because there are very few providers. Population is sparse.
5 It's difficult to spread the fixed cost and to cover risk.
6 And there's limited opportunity for efficiency gains.
7 As we say, there's little evidence of entry or
8 interest by managed care plans in moving into rural areas is
9 the bottom line.
10 We looked at a few other options. Private fee-
11 for-service is an option that's actually happening. The
12 same providers, payments, no management of care, so there's
13 not any scope for efficiency gains. There are additional
14 expenses for the plan: marketing and administration. There
15 are additional expenses for Medicare because of the floors.
16 And as of right now, under the current plan there are
17 additional premiums for beneficiaries. So it seems to be a
18 pretty expensive way to get not much in the way of extra
19 benefits.
20 DR. WILENSKY: I think we're all fearful of that,

but it strikes me that we ought to wait to see how they share the bounty before we make that kind of a conclusion.

MR. GLASS: That was one of the recommendations from the March report was to see where they go.

DR. ROWE: What's the experience, David, so far?

DR. WILENSKY: We don't have any.

DR. ROWE: In terms of the private fee-for-service, in terms of volume?

MR. GLASS: Scott, where are we, about 10,000, 20,000 now?

DR. HARRISON: 13,000.

MR. GLASS: 13,000 enrolled so far across the country.

MS. NEWPORT: And they've been enrolling since September of last year?

DR. REISCHAUER: But to the extent that there is a bounty now, they haven't shared it at all. As a matter of fact, they've taken more money out of the pockets of Medicare beneficiaries to get what the fee-for-service plan --

MR. GLASS: Yes, currently there's a $65 a month premium.

DR. ROWE: Because there's a premium. But they're not getting any benefits for that premium?

DR. WILENSKY: No, they are. But the question is what?

MR. GLASS: There are different cost sharing provisions primarily. And there's some coverage for like when you're out of the country benefits. But then again there's also a 30 percent coinsurance on home health, for instance.

DR. ROWE: There's some benefits so when these poor rural, frail elderly Medicare beneficiaries are traveling to Rome, they're covered under it.

[Laughter.]

DR. ROWE: What was the expected enrollment by now? There must have been a projection as to what was going to happen. Do we know, Scott? Was there a guess? Is this much lower than expected, about what was expected?

DR. HARRISON: In conversations with the company,

I don't think they wanted to be that aggressive to start with. I think they wanted to go build slowly, so I suspect they're probably about where they want to be right now.

DR. ROWE: And all the beneficiaries are in one company?

DR. HARRISON: Right now, yes.

DR. WILENSKY: It's actually been astounding -- this seems like such a good deal for the companies -- as to why this hasn't been happening, other than perhaps slow approval by HCFA now.

DR. ROWE: I think in the analyses that are being done in the companies themselves it sounds like it's a less good deal than --

DR. WILENSKY: No, we're not talking about the M+C in the rural area. We're talking now about private fee-for-service where you don't --

DR. ROWE: No, I understand.

DR. WILENSKY: -- you don't have the need to give back all the additional income as benefits. I guess the answer is, apparently not, because they haven't shown up.

DR. ROWE: Not so far.

MR. GLASS: There is apparently another plan that has now applied, another private fee-for-service plan.

DR. WILENSKY: We would have thought there would have been a rush on early on, and it did not happen.

MS. NEWPORT: I would suggest, respectfully, that right now the phrase, widely available, in reference to private fee-for-service is somewhat an overstatement. I think the inference in the report -- and the concerns are grounded, but I think for a plan that's still got 1 million members, 13,000 to 14,000 isn't exactly a bullet at this point.

I think the issue for plans in looking at this, established traditional M+C Medicare risk plans is finding a line of sight to what's going to happen on Medicare reform, a line of sight on what's going to happen on regulatory simplification, before you start building maybe a not-existing infrastructure to do basically a type of claims processing in rural areas. I think those issues interfere in terms of the structural base that a traditional M+C plan

1 would have, inasmuch as we've got three years of tradition
2 on some of this stuff.
3 So I think that it's early days, but if you go
4 back to pre-BBA when HCFA had a queue of 60 to 75
5 applications, and now the queue is six to seven
6 applications, then I think the problem is broader. I think
7 this registers as something to watch with some level of
8 interest in terms of, is this an efficient way to go about
9 this? Will the consumer response eventually -- because it's
10 just started up -- plateau, decline? Med supp comes in or
11 looks better?
12 I think that there's all sorts of variables that
13 need to be looked at, including maybe a pretty efficient
14 broker, a network that's selling this well. It may not be
15 at the end of the day very good, but I think there's a lot
16 of things. I just think that it's early. It's not
17 something that overall you see any entry into M+C, much less
18 this.
19 I just caution that we watch this prudently, but
20 I'm not sure that it's something at the end of the day with

1 Medicare reform coming down the line that will be meaningful
2 or not. I don't know how to draw a conclusion. I just know
3 that there's not a lot of interest in doing this yet.
4 DR. ROWE: This is, I think, an interesting issue
5 for us to discuss in this context. What I'm hearing from
6 Janet, and maybe elsewhere, is a kind of lack of trust.
7 Yes, it appears it would be a good opportunity, but they
8 killed us on this other thing; what are they going to do
9 here? We'll get going, then they'll crash the budget until
10 we're in crisis. Then they'll say, oh, we cut too much.
11 You're in crisis, we'll have to give you something back.
12 But by then we would have had to pull out of the market.
13 It's that kind of concern about Medicare as a
14 partner, I guess, that is limiting people's attraction to
15 this. I don't know. Do you know?
16 MS. ROSENBLATT: I don't know why we haven't
17 looked at it. I don't even know if we have looked at it.
18 But I was going to comment on this because I think the text
19 is extremely negative about these plans and led me to ask
20 the question, what did people who allowed this to exist, who

suggested let's have private fee-for-service plans, what was the goal of having it? I know it's too early to measure if we're --

DR. HARRISON: It's not what you'd expect. The original proponents were actually concerned that the budget was being cut on Medicare too severely and people would have trouble -- they were afraid basically that elderly would be euthanized. This was an ideological plot. So the idea was that you would be able to join a network and actually pay physicians more to make sure you got the care you needed.

DR. WILENSKY: But it's a problem, a particular problem because of the floor issue. Otherwise what you can say is, if a company is able to convince somebody they should pay a premium to get very little in return, then there may be some marketing questions about why seniors think that this is a good idea, except maybe if it's to get access to a pool of physicians who don't participate in Medicare. There are some physicians who don't participate in Medicare. It's not a big problem as best as we can tell, but there clearly are some physicians.

This was a way to allow people to get around some of the existing Medicare reimbursements in a way that was consistent with Medicare law.

It becomes much more costly because of the floor counties, which now guarantee very large differential in some parts of the country if the senior chooses of plan of any sort that qualifies for floor county reimbursement as opposed to staying in traditional Medicare, where at the extremes you have these very wide bands of differences.

So now the question could well be, as long as the senior gets some benefit, even if it's a 90/10 split between the plan and the senior, it still may make sense for seniors in terms of they'll be better off, but it is a very high price to pay for getting a little additional benefit to seniors.

So the issue of whether or not private fee-for-service plans ought to be allowed, if they were attractive to seniors, if you have the government paying the same amount irrespective of what plans people take, I think is not a big deal. I was not concerned about that at that

level. I think people ought to be able to buy what the rest of think is a not very good plan if they choose and they know what they're buying. But it became very different the larger the disparity between what the government pays under traditional Medicare and the floor county. Then it became a very serious issue.

MS. ROSENBLATT: If we could just capture a little bit of the flavor of what you just said because -- even though we're focused on rural, so we're focused on the floor. I think that the text is just losing a little bit of that overall.

DR. WILENSKY: I agree. I think we ought not to damn the concept as much as the issues that, because of a series of changes that have occurred, have made the potential cost of the program much greater. Again, I personally regarded it as an okay option to have available to choose.

DR. REISCHAUER: If a private entity can provide a Medicare-like service which is open to all eligible people on a regular basis more efficiently than Medicare can,

because it's administrative system is better, because it pays certain kinds of providers -- it doesn't overpay certain kinds of providers, great. I say we should encourage that.

DR. WILENSKY: It's really the floor issue that made this a problem.

DR. ROWE: But last year when I was sitting there and you were sitting here you said this was a license to steal.

DR. REISCHAUER: Because of the floor.

DR. WILENSKY: It's the floor. It's not the plan.

DR. REISCHAUER: It's the floor. I'm saying if you can do it more efficiently than Medicare does it in western Nebraska, great.

DR. ROWE: So as an economist though you're faced with the fact that it's a license to steal because of the floor but nobody's stealing.

DR. REISCHAUER: Yes. That's an interesting -- makes you want to rethink human nature.

DR. ROWE: Or economic theory.

[Laughter.]

DR. WILENSKY: No, I think you really hit it, which is the distrust.

DR. REISCHAUER: I think Janet put her finger on it which is, if this took off and lots and lots of people joined, Congress would scratch its head and say --

DR. WILENSKY: Say, what have we done?

DR. REISCHAUER: -- why are we spending all this extra money for basically what people can get a lot cheaper?

MR. HACKBARTH: People are uncertain just by selection risk. If you were considering going into this business you'd want to move slowly and not get out in front of yourself.

DR. ROWE: Having been burned before. But I just want the record to show that only an economist, when there is a difference between human nature and economic theory would say that human nature was wrong.

[Laughter.]

DR. NEWHOUSE: Sometimes we say the data are wrong.

MR. HACKBARTH: I think the point that Alice made about the tone and your language is a good suggestion here. Beyond that though, I'm unsure why we're reviewing all of this again. We went through this in March. It would be helpful if you would identify what's different that we need to talk about again.

MR. GLASS: I'd be delighted to. There is no difference. We're just running through this. In fact we can switch to the next slide which is the conclusions, which are also the same. The only thing I wanted to add here was, in this whole discussion we've assumed risk adjustment is possible. You could say, if risk adjustment is delayed, fair payment is denied or something.

But we may want to come up with some kind of interim solution recognizing that in fact risk adjustment may not be practical for HCFA to figure out how to do it, or Congress may never allow it to happen. So we may want to think about, should we consider some interim solution during the time in which risk adjustment doesn't happen, or would there be an interim solution that would make sense if there

is no risk adjustment? In the March report and all that we assumed that we want to make payments equal on a risk-adjusted basis. What if you can't?

DR. WILENSKY: Is there a reason that we aren't talking more about some of the shared risk ideas that we've talked about in the past?

MR. GLASS: We didn't have anything new to say about that today, so I just whipped through that. But yes, that is in the text.

DR. NEWHOUSE: I had three comments on the chapter. One, although we've all, I think appropriately been, at least dour and negative about floors, I think we should say in the chapter the small metropolitan floor may well bring additional benefits in those areas, because there you typically will have competing plans and benefits will pass through.

MR. GLASS: That may be true, but this is a chapter on rural M+C.

DR. NEWHOUSE: But it kind of takes on floors generally. I think it is what the Congress was trying to

do, and we've been so negative about floors that we probably ought to say that.

The second point, on page 10 -- I had brought this up last time. I disagree with the analysis there that M+C plans don't go into rural areas because they can't spread the risk. They can spread the risk over all the beneficiaries they insure. There's no law that says they're limited to spread the risk over just that county. I gave you the example that life insurance companies sell plenty of life insurance policies to people in rural counties and they think they're spreading the risk over everybody they sell a life insurance policy to.

MR. GLASS: Yes, I brought up a little later in regard to that point that spreading over more counties though increases their network formation problem.

DR. NEWHOUSE: But that's not a risk issue. That's a cost of doing business in the area. I guess my reaction to that is, there's probably a fix cost per provider you contract with, and they're contracting with fewer providers out there too than in metro areas. So I'm

not sure that whole line of argument is very convincing.

I think you should rest your hat on the structural problems: that it's very hard to get discounts, and it's hard to enforce compliance because you don't have any leverage with so few providers.

My final comment was on the split capitation option, which I think there's another problem with that that you don't bring up, which is that there's an incentive for the group practice, whoever is getting the risk payment, to unbundle and, for example, shift services to the outpatient department, which we wouldn't want to see happen.

MS. ROSENBLATT: I just had one other comment. I'm not that familiar with cost HMOs and there's a section on cost HMOs. I just thought those were mostly staff model, that there was something about them that caused it to be more attractive to staff model HMOs than to other. Again, I'm talking about of close to total ignorance about the cost HMOs.

MR. GLASS: I'm not sure what the split is.

DR. HARRISON: Most of the ones I'm aware of are

staff model, but -- for instance, Kaiser would have --

MS. ROSENBLATT: There's something in the way the reimbursement works that would make it unattractive if you're not a staff model.

DR. HARRISON: It's because what you're doing is you're providing benefits to the beneficiary, and if the beneficiary uses your network then they get the benefits of lower cost sharing. If they go out of network it's regular Medicare. So if you don't have a network and you're not providing something additional for the beneficiary, there's not much interest by the beneficiary.

They are scheduled to end, I believe in 2004. And some places like Kaiser has both the cost and Medicare+Choice in some areas but the cost plan has closed.

DR. NEWHOUSE: Any other comments on this chapter?

DR. REISCHAUER: There's this little example which came up in an earlier chapter too and I thought I beat it down, but maybe not. This is the sort of, gosh, in some of these areas with the floor we'd end up paying the private fee-for-service plan more than it would cost to buy a

Medigap policy. You make it sound like Medicare would save money by making this option available. And of course, everybody would take this option if it were available.

You ought to make sure that some bright-eyed, bushy-tailed staff member of Congress doesn't look at this and say, great idea, let's go ahead with this one. Then we'll have CBO score it as a savings.

MR. GLASS: I thought we said that having Medicare buy Medigap coverage would clearly not be an appropriate solution or good public policy.

DR. ROWE: But you don't say why. Actually as I recall, you go to the point of saying, you can Medigap C. You actually say which Medigap you can buy. And then you say, but of course we wouldn't want to do that. I think that people might say, wait a minute, maybe we would want to do that. So you might want to put some more stuff in there. I think Bob is right, because of the specificity of going to C and -- it's too concrete for them. I'd say it's too attractive.

MS. NEWPORT: I have a comment on the cost

contracts too, so I'll try to wander my way through. I think you have to put some construction around a couple of thoughts in the paper in a historical context.

For example, private fee-for-service came in in BBA, purposefully or not, as BBRA and BIPA came along with working on the floor. They may now be perceived to be the unintended beneficiary of something that probably wasn't part of the matrix or thought process in the first place. I think that that sort of has happened that way. But I think that recognizing the concerns and the consistency with our earlier report, I don't have a problem with that, but I think you need to amplify a little bit on those areas just to give the accurate point in time that some of these things happened.

I think on the cost contract issue, cost contracts that are still out there came about in the '70s. I think they are primarily staff model, urban-based, because that was the only way plans could participate in cost contracting at that point. That's the only way you could get into Medicare. So these are artifacts that I think have worked

in a certain way because there was an age-in effect. Not a lot of explicit, direct marketing. People aged into it from employer, under-65 market accounts. So therefore, the costs were much easier to work with.

I think that that speaks to me to something on the partial risk idea, is that one of the reasons to me that doesn't necessarily work from an operational standpoint is that it doesn't seem to me there would be any diminished regulatory overlay. There may be an additional regulatory overlay. So I think I would caution, put some framework around that. That I'm not sure that that would work.

I think the issue of the large employers that you raise on page 6 -- and I don't mean to say it's an issue -- is up until BIPA there was regulatory constraints on a higher market penetration in the employer accounts. One of the good things out of BIPA was that some of that -- there was authority given to HCFA to loosen up some of their regulatory -- I don't know, there were just some barriers to having more flexibility and creating employer-retiree programs in Medicare.

1 So the emphasis in the chapter, to me would lead
2 people to the conclusion that somehow this is something
3 that's been clicking along and working very well up till
4 now. I think it's too soon to come to that conclusion. And
5 HCFA actually convened a serious three-day meeting last year
6 on this issue and part of the result of that meeting was
7 some changes in BIPA. So I would back off that just a
8 little bit.
9 Then I think part of the chapter also talks about
10 the confluence of interests that came together in, I guess
11 it was BBA, that started to address the payment issues in
12 rural areas. It wasn't just that rural areas wanted the
13 better benefits.
14 I think there were other influences in place,
15 including in urban markets like Minnesota where the initial
16 penetration in the marketplace on Medicare+Choice TEFRA
17 contracts at that point, they were so successful, the
18 moderating impact on fee-for-service payments in the area
19 upon which their payment was based, the lines in the curves
20 crossed and they were now getting payment decreases instead

of increases. I think the solution to that is rebasing the payment system that came out in BBA.

I think we should reflect that a little bit and not just make it sound like it was only because we wanted to put more benefits in the rural areas. I think that was part of it. But I think more importantly, the push was to rebase certain urban area payments so that we were bringing them up to what the fee-for-service cost scale was.

So I just think those are constructs around this that make it a little more accurate, and paint a little more refined or a rigorous picture about what happened.

MR. GLASS: We're just very focused on the rural, but we can add the other to the context.

MS. NEWPORT: I think that's right, but I think there were a lot of other things that, if we had known then what we know now I think the pile-on -- in some ways a good way -- all the other subsequent legislation has led to some things that -- I just think you need to fine-tune that.

DR. WILENSKY: Any further comments?

Thank you.

Kevin?

DR. HAYES: We're here to talk about a draft chapter for the June report on estimating the payment update for physician services. You recall that the update for physician services is based on a formula called the sustainable growth rate system. This is a system designed to control spending while accounting for changes in the cost of providing physician services.

The question before us concerns HCFA's estimate of the update for next year, 2002. The question being, is this a reasonable estimate? HCFA is in a position of generating such an estimate because of requirements in the Balanced Budget Refinement Act of 1999. The law required HCFA to develop an estimate by March 1st for the coming calendar year. And we are required to review that estimate in our June report.

There is a larger issue at work here having to do with the Commission's recommendation in the March 2001 report that the Congress replace the sustainable growth rate system. As you recall, the Commission's concern was that

the system does not adequately account for the factors affecting the cost of providing physician services, and it's also believed to be a poor mechanism for controlling spending.

Despite this issue, despite your recommendation we are obligated to review HCFA's estimate and include that review in the June report, and that's what we're here to do.

Our next slide just reviews the estimate that you saw last month. Looking at the bottom line here, the estimate is that the update would be a minus 0.1 percent. The notable thing about the estimate is that it is lower than the expected change in input prices for next year of 1.8 percent. The reason for that has to do with the negative update adjustment factor that you see here of minus 1.5 percent. This negative adjustment accounts for an expected difference between a target level of spending for physician services that's determined by the sustainable growth rate and expected actual spending for physician services.

Your discussion last month, first I believe you

reached a conclusion that HCFA's estimate appeared to be reasonable. But you also wanted to see a reiteration in the chapter of the recommendation in the March report about Congress replacing the SGR system, so we tried to address those two issues in the draft chapter that we sent you for the meeting.

So our hope is today that you would address these two issues here of whether the draft chapter adequately reflects the discussion at last month's meeting. And secondly, whether the chapter overall is ready for the June report.

MS. ROSENBLATT: Unfortunately I missed the discussion at the March meeting, but I think we all got letters from the AMA suggesting that we present some other scenarios. I actually thought that was a very good idea because I don't think that the rank and file physicians know about the sustainable growth rate. I made a presentation to the Blue Cross of California Physician Advisory Board on Wellpoint's change to the fee schedule and I mentioned the sustainable growth rate and it's like they had never heard

about it.

So I think illustrating that this could go more negative than minus 0.1 I think would be a very powerful statement to make and be educational, because I just don't think it's known by physicians right now. It's obviously known by the AMA, but I don't think that -- even a sophisticated group of physicians which are on the Blue Cross board, they did not know about it.

DR. NELSON: Kevin, I think you did a darned good job with what you had to work with. But I'd again point out that Congress doesn't like surprises and that this negative update may indeed be an optimistic projection, given the current state of the economy and the trend lines on use rates.

I think we ought to build in here the possibility that this indeed may be optimistic, and that it's not outside the realm of reason to consider -- to have more data reflect an update that's negative 3 percent or 4 percent. I don't think we need to say numbers, but I think that the probability of more data revising this downward is a good

deal more likely than the probability of more data revising it upward, and that we ought to let Congress know that we're concerned if that turns out to be the case because of our concerns about access.

Any negative update raises concerns about access. But if it's several percentage points -- I mean, physicians may be uninformed about the SGR, but they know if they're losing money. I think that there are two audiences for us then. One would be to give an early warning to physicians that until the SGR is fixed that the economy may reflect itself on a reduction in Medicare payments, so get ready for it. But the other audience being the Congress who expects us to say that, if that is indeed our sense.

MR. HACKBARTH: I agree with Alice and Alan. I think it would be a useful addition to highlight that this number could be off by a fairly significant amount, depending on how the economy changes and the updated information on expenditure patterns goes.

DR. ROWE: When would we have a better idea? When would be the date, Kevin, that you estimate we would be able

to address with greater confidence where we would be going?

DR. HAYES: I would say by the September meeting we would know more. A key issue here has to do with what happens to actual spending for physician services. This estimate that we saw today is based on complete information for the first two quarters of the year 2000, and partial information for the third quarter, none for the fourth, and none for 2001. After some time elapses here however, you could imagine we would have complete or fairly complete information for 2000 and even some preliminary information for 2001.

DR. ROWE: I would think then if we're going to send this pre-announcement message about it might get worse, in fact substantively worse, we should either delay this message if we think this is going to be misleading -- but we may not have the flexibility to do that -- or put a date in at which point we would have more specific information. Just hanging out there and saying, this may get much worse, guys, without any kind of timeframe for decisionmaking or action or reaction or anything else, might not be that

helpful.

DR. NELSON: I'd like to respond to Jack. We have to say something now. Now certainly we would say, this is the best that we can say and it's pretty darn poor, and we'll come to you with a better projection in the fall. But I still think it would be good to send a signal now, since we have to send a signal. We're legislated to make some comment on it. I think we ought to send a signal now that says, we'll --

DR. ROWE: It's more likely to get worse than better. I concur completely.

MR. HACKBARTH: In the fall we're not talking any longer about estimates. We're talking about setting the final number.

DR. HAYES: Right, the final number comes out --

MR. HACKBARTH: So to say, we can tell you a better estimate when the final number is set isn't very helpful from a policy standpoint.

DR. HAYES: One question that we need to consider here has to do with how much detail we provide at this

point. I've heard two things here. One is that we should just indicate to the Congress that the update that comes out in the fall could be lower than the minus 0.1 percent that we have an estimate about now.

The other issue just has to do with -- and this is reflected in the AMA's letter -- has to do with whether we should come up with some alternative scenarios, if you will, whether we should generate some possible alternative updates for next year. I would appreciate some kind of a sense from the commissioners about this. I would say that from my standpoint, we have not been proceeding with this review on the assumption that we would actually be generating estimates ourselves, but rather that we would be reviewing estimates that come out of HCFA. But some read on that would be appreciated.

MR. HACKBARTH: I would shy away from making our own estimates, or even doing scenarios that might be perceived as estimates. I don't think we have any information on which to make better estimates than anybody else. But what we can say is that because of the inherent

characteristics of the system the number could be dramatically different than this. And to me, that's part of the problem with the SGR system, is that it hangs on these big imponderables that could make it depart significantly from input prices.

MS. ROSENBLATT: Even though I suggested earlier in my reference to the AMA letter doing the alternate scenarios, I agree with what Glenn just said. I was just thinking back to our conversation yesterday and how we all reacted to the 67 percent. I think you're right, if we did alternate scenarios it would be taken as more than was intended.

DR. BRAUN: I think when we talk about it possibly being worse I think we do need to refer to the fact that we have concern about access problems.

DR. LOOP: I agree. Are we trying to measure physician services or are we trying to control spending? When I read this it seems like we're trying to influence physician behavior economically and to be sure that the physician doesn't make any money. But the average guy

that's out there in practice is going to get whipsawed. There's oversupply and undersupply, and yet all these adjustments are applied across the board, and the practice of medicine is much different all over the country.

So I think that you can't staff or budget or perform when you're whipsawed like this. I really think this is going to go down very poorly, particularly if it's worse than the negative 0.1 percent.

DR. WILENSKY: You're raising an issue that's inherent in the relative value scale, sustainable growth rate combination. There never really has been an intent to affect behavior with such a global mechanism at an individual physician level.

At most what the argument has been for volume performance standards before them, and sustainable growth rates, is that it's a way to try to limit aggregate spending on physicians. The argument was that the relative value scale would better adjust the payments per procedure, but the overall conversion factor, how that translates into money, would be tied to these global spending rates.

As long as that's driving the system, it's very hard to move away from that. It's why in the spring -- it's one of the reasons we had suggested moving to a system that tried to look at various factors and build them up from the ground like we do in the hospital area, taking account of technological change or input prices, and try to make adjustments on that basis rather than following current law and current practice.

But I don't disagree with you that this never seemed like very much of a way to change individual physician behavior. If you wanted to do that you'd have to monitor their volume, the individual physician's volume, and basically if their volume started going outside some pre-set bounds, to affect their own fees if you really were looking at this as a way to try to influence behavior. Now there are a lot of reasons that people didn't really want to go down that path, but that at least attempts to change individual physician behavior. This really is just a way to try to cap overall spending.

I think we primarily have said our concerns about

the general strategy that we use in our March report when we suggested that we abandon the SGR concept and try to build up a series of mechanisms to give us a way to recommend update changes. I think we're just sort of reminding ourselves about some of the dissatisfaction that we felt with current law. I don't know how else to respond though, if there's any other ideas about how to try to change this.

DR. BRAUN: I was just curious, has anyone ever done a study -- the growth rate situation made me think of something. Has anyone ever done a study about what the growth rate does in relationship to the economy? I mean, I can just see the rise in anxiety, and psychosomatic illnesses and so forth and so on, going on when the economy is in recession that would raise that growth which would have really nothing to do with physician behavior, it's behavior of the patients. I wonder if anybody has ever done any work on that.

DR. HAYES: It's funny, we haven't, and I'm not aware of any studies like that, although they may be out there. But it would be an easy enough thing to do. We

1 certainly have the historical information on both things,
2 the growth in the economy and changes in spending for
3 physician services and volume of services.
4 DR. WILENSKY: Are you talking about for the
5 elderly, per se, or for the economy as a whole?
6 DR. BRAUN: The economy as a whole, but that, of
7 course, impacts the elderly as well as everyone else.
8 MR. HACKBARTH: It goes both ways. To some
9 degree, care may be elective and people may not wish to pay
10 copayments and put it off until -- of course, that would be
11 more of an issue in the non-elderly where you're talking
12 about a working population.
13 DR. ROWE: Or lose their health insurance.
14 DR. NELSON: Kevin, here again I think HCFA
15 probably made a reasonable guess on the increase in services
16 that result from legislative changes. But my guess also is
17 that they were looking just at the increase in spending on
18 those specific services and not the domino effect that can
19 occur when a patient comes in for colorectal cancer
20 screening, for example, and has a false positive, so then a

whole series of additional studies are necessary to track it down. So a simple preventive service being counted as that is one thing. But the encounter itself and the screening service may prompt a lot of other unintended follow-up.

I'm not saying that we should tell HCFA to change its number. I just think it's something that we have to look at. It may be that there will be some lessons with respect to the impact of legislative changes that increase screening that we can learn from.

DR. WILENSKY: Enough guidance?

DR. HAYES: Yes.

DR. WILENSKY: We're going to open it up for public comment now.

MS. McELRATH: I'm Sharon McElrath with the AMA. I'd like to thank you for deciding to add some more context to that report. The one other thing, to just follow up on something that Dr. Nelson said is that what we get from HCFA, there's not any detail on the law and regulation section. So you can't really go back and see why they predicted what they did there and whether it was actually

accurate or not. So just something to think about in the future if we remain under this system, it would be good to know more about what's actually in that estimate.

DR. WILENSKY: Any other comment?

We're going to break until noon, and reconvene at noon to do our last session.

[Whereupon, at 11:23 a.m., the meeting was recessed, to reconvene at 12:00 p.m., this same day.]

AFTERNOON SESSION [12:09]

DR. WILENSKY: If we can get started?

DR. ROSS: I guess this is all ashore that's going ashore. As we mentioned in executive session yesterday, we had asked the Lewin Group to do an analysis of Medicare payment rates to skilled nursing facilities in Alaska and Hawaii in preparation for a report that the Commission is mandated to submit next month. I'd like to welcome Al Dobson, senior vice president; Joan DaVanzo, vice president; and Lane Koenig, senior manager. They're going to present and we anticipate sending a fairly brief letter/report along with their contract report to the Congress to meet the deadline in mid-May.

Thank you.

DR. DOBSON: I understand we don't have overheads. I'll just tell you what page I'm on and we'll go through these slides.

I'm very pleased to be here. I looked at my notes this morning. The last time I was before the Commission was February 2nd, 1984 -- it's been a while. At that time I

presented the outlines and architecture of the then brand new PPS. You folks have taken very good care of the baby over these years. It's probably one of the most viable, current, strongest, best payment systems in the world, and I'm right pleased to see you took very good care of it.

Page 2. In terms of issues, the 1999 BBRA asked MedPAC to take a look and see if there were some unique circumstances for SNFs in Alaska and Hawaii. The basic question was, should there a COLA or an additional payment made for higher cost in the non-labor portion of the payment amount?

As we turn to page 3, the current payment system, as with most systems, has a labor and non-labor portion. The labor portion is about 78 percent, the non-labor portion is 22 percent. The question before you is, should that 22 percent be adjusted for something like a cost-of-living adjustment in the states of Alaska and Hawaii?

The system is currently in a three-year phase-in which ends roughly this July, and at the end of that phase-in there will be no COLA adjustments for the skilled nursing

facilities in Alaska and Hawaii.

Now on the next page we take a look at what a non-labor factor is, page 4. The drift of it is, in Alaska and Hawaii the argument is that utilities, other products, telephone services, non-labor intensive services, whatever that is, and capital related expenses are more costly. You can kind of imagine why that might be the case in both situations, Alaska and Hawaii.

Indeed, when we built the DRG system we did put an adjustment factor, a COLA adjustment in for our PPS at the time on the non-labor side, something on the order of 25 percent relative to Washington, D.C. So at that time we made the judgment, and I remember making it, that we basically said, these places are pretty extreme, let's put an adjustment COLA on the non-labor portion.

Now I'm going to summarize a series of tables. Unfortunately, there's no one knockout table that I could present to you today that basically says to you as commissioners, this is the answer that you're looking for. I'm going to provide you a series of tables that kind of go

1 from hither to yon which suggest, by and large, that costs
2 are higher in Alaska and Hawaii, but you're going to have to
3 make some very careful deliberations on whether you think
4 they're high enough to merit a COLA in the non-labor portion
5 of the SNF prospective payment.
6 Turning to the first table, page 5, here we took
7 the 1998 Medicare cost report information on cost per case
8 basis and we asked ourselves the question, how do the
9 inpatient hospital costs rank? What we find is, Alaska
10 number one, Hawaii number two, Maryland a fairly distant
11 number three, then Maine, and D.C.
12 Now the problem with this slide is several-fold.
13 First, it's inpatient acute care, not nursing homes.
14 Although in Alaska, most of the nursing homes are hospital-
15 based. Secondly, we get all mixed up here in prices and
16 quantities because this is a cost per case. It has labor,
17 it has non-labor in it, and it also has various volumes of
18 labor even though we do adjust, as you can see in the
19 footnote, for case mix, wages, teaching, and
20 disproportionate share.

That said, it's still interesting to note that on this measure at least -- this is the cleanest one we have -- that Alaska ranks number one and Hawaii number two.

Now the next thing we looked at, we asked ourselves the question, what about the GPCI, which you folks have dealt with over the years on the Medicare fee schedule? On page 6 we note that if you take a look at the GPCI which accounts for rent, supplies, equipment, the kinds of things that are in non-labor adjustments, we see now that Alaska and Hawaii are no longer number one. Indeed, number seven for Hawaii and number 17 for Alaska. Now you might say this is a little bit of beside the point, but it had very much the feel of the kinds of things we were looking for.

Now on the next slide we do cost-of-living indices, and now things start to get truly messy in that when we went on the Internet and we did our research we couldn't find cost of living. In fact, for instance, some of the indices have Alaska in them and some of them don't.

So we provide you two indices on page 7. You will note that for Alaska, which did not have Hawaii in that

particular index -- that would be the Chamber of Commerce I guess -- that Kodiak, Anchorage, and Fairbanks on these particular measures cost of living, were number two, three, and eighth in the nation respectively at 36 percent higher on food. Hawaii, on the other hand, in another index was 51 percent higher on food.

As you move down to utilities, Kodiak again is ranked number one in the country at 200 percent higher on utilities, whereas Hawaii was 136 percent higher than the U.S. average. Miscellaneous goods and services, Kodiak is 26 percent higher where Hawaii was essentially the U.S. average. And for health care, Fairbanks now was number two in the country at 68 percent higher, and then in Honolulu it was 19.2 percent higher.

DR. ROWE: Could I ask you a question about Kodiak? That's interesting, but my understanding is that Kodiak is an island, it's out there just in the southern part of the beginning of the Aleutian chain. It's got a very small population. Not that this state has a large population. But you could have found maybe Unalaska Island,

which is I think the furthest out and last inhabited one on the chain, and that may have been even higher, if they had data for it.

What does that tell us? Why is it worth including some small, little island like that? I can see Fairbanks, although it's so far north --

DR. DOBSON: Let's take Anchorage. Anchorage is number three, right behind Kodiak -- on the miscellaneous goods and service, Anchorage is number three behind Kodiak at two. We looked at the map, as you have in your head, and we too came to the conclusion that Alaska is very sparsely populated with cities all over the place, so to speak, with no roads -- you've been to Alaska -- no roads, et cetera.

We thought that Kodiak, Anchorage, and Fairbanks -- we picked the ones that were highest, Anchorage being an anchor, if you will, excuse the bad pun, and it's right behind Kodiak. So I think that the central tenency here is pretty well spoken for in that Anchorage and Kodiak were roughly the same order of magnitude.

MR. KOENIG: We tried mapping actually, the ones

that we could in Alaska, the SNFs on a map, and we were able to map one to Kodiak. So we're talking about one in Kodiak. So from what we could tell there's at least one.

DR. ROWE: There is a SNF there?

DR. DOBSON: Yes. Now on the next page, page 8, we'll look at some composite measures. In Honolulu, Hawaii, it's the fifth most expensive city to live in. This Rumsheimer International Index, it had a 150 items in 10 categories. Here we again have Kodiak, Fairbanks, and Anchorage at fourth, fifth, and sixth in another index, the Chamber of Commerce.

Now things get a little more interesting, and a take-home point for you today is that when you look at least these two indices what you see is that California cities, New York, Manhattan, and Boston, lie above Honolulu. And we look at the Chamber of Commerce index -- not on your slide but in our report -- again, Manhattan, a California city, L.A., Long Beach, and Boston lie above Kodiak. So what we have now on this measure is, you have to ask yourself the question, why Hawaii and Alaska when you have New York,

Boston, and California cities that are higher on at least this particular index?

Now we have some anecdotal information. We called folks in the state and we said, what's going on in your state vis-a-vis prices? You can imagine the sorts of things we heard. But we learned about dry ice and overnight stays and bush pilots and all kinds of cool things actually. But the point of it is that freight and transportation of goods to offshore states -- Alaska is a little bit of a mixture, but any rate non-mainland -- are more expensive. Particularly when you move away from Anchorage and you have to get somewhere, generally you don't drive it, you fly it. And therein lies some problems with expenses.

We also heard the cost of repair and maintenance is high because they bring folks in from Seattle or from Anchorage to fix stuff up for them. That costs money. The unavailability of required goods and services in a local market means you have to bring it in. Very much like Puerto Rico in that sense. I just happen to know a little bit about Puerto Rico as well.

Finally, one that was most compelling but we left off your list, so you can add it back on, if you would for us, is the cost of recruitment and maintaining a workforce. Imagine being in Kodiak trying to recruit somebody. You've got to go to Anchorage at best, maybe to Seattle, to find people that you're going to recruit. And then you've got to convince them to come live at the end of the road which is probably going to take some special considerations.

It's anecdotal, but it does seem, I believe, somewhat interesting to note the kinds of things that people that run the institutions both in Hawaii and Alaska pointed out to us.

Now what are you folks to make of this? The first thing you could do is say, this is really compelling stuff. The inpatient hospital looked pretty solid, one and two. Let's recommend to Congress we go along, follow the COLA that's already in PPS, seems good to us.

Then you could say, gee, you got California, you got New York, you got Boston on some of these other indices and they're very much higher than Alaska and Hawaii. Glenn

1 knows that well, doesn't he, now?

2 Then you could say, we don't have enough

3 information. Maybe the department ought to look a little

4 more carefully.

5 What might they look at? They might adjust the

6 very first index we talked about, the inpatient hospital

7 care to get rid of those quantities. For instance, you

8 might divide through by length of stay, you might divide

9 through by FTEs per bed or some such thing to try to get

10 more of a pure price measure and see if that looks right.

11 You might go in and get the per diem SNF amounts that were

12 used to calculate the PPS. MedPAC doesn't have them;

13 presumably HCFA does, although they're not easily accessible

14 we understand.

15 You might look at that and ask the question, after

16 you take a look at per diems and you rank them, Alaska,

17 Hawaii, where do they fall in the rest of the country? You

18 might match up costs and you might say, if they're making

19 money hand over fist -- which I'm not saying they are or

20 they aren't -- then you say, what's an adjustment for? On

the other hand, if there's a big discrepancy and they're very highly ranked on SNF per diems, which is what SNFs are paid on, then you might argue, maybe this thing is legitimate.

At any rate, those are the options as we see them, and that's my presentation. Did I make 10 minutes, Gail?

DR. WILENSKY: Thank you. It was terrific. It was interesting and a very focused presentation.

Because I know we are in danger of losing two commissioners in the next 10 or 15 minutes I'm going to make a proposal for people to think about with regard to these options and then just open it up to discussion either on the facts that were presented or on the options.

I'm going to recommend, in order to try to focus the discussion but obviously you're free to make any alternative recommendations you'd like, is that we combine two of recommendations. First that we have the Secretary collect additional information to evaluate these differences, whether the differences are justified. I think some of the ideas that you just raised are very interesting

ones and ought to be included in a discussion to make sure there's flavor. I think that's very valuable.

Then to also recommend that in the interim, while this information is collected, that the COLAs continue, on the grounds that they're --

DR. DOBSON: Strictly speaking, Gail, the COLAs phase out as of July of this year because the prospective payment system on labor part does not have the COLAs in them. The non-federal portion does have COLAs, but that will be phased out this July roughly speaking. It was a three-year phase-in.

DR. WILENSKY: I guess my inclination had been to put it back in. To basically have it in, see whether or not it is justified. I do believe there's enough anecdotal evidence to suggest that it may well be, but when that study is done, then to assess whether or not it should continue. So it would taking the first diamond and the third diamond and putting it together.

DR. ROSS: Could you just clarify on the third diamond whether looking just at SNFs in Alaska and Hawaii,

or for all SNFs? Because if you get into the all SNFs you start to raise the issue of --

DR. WILENSKY: I had meant only this -- we have already made a very strong recommendation about our views of reimbursement to SNFs using the RUG classification. Basically, stop fiddling around and try and find something else. So it seems to me we have made a very strong statement about what we think about the general reimbursement issue. I would regard this as specific to Alaska and Hawaii.

So I'm opening it up as a point of departure, but it strikes me that we definitely need to get some better information, and in the interim to keep the payments.

DR. ROWE: Can I ask whether or not other remote areas that come under the jurisdiction of the United States like Guam, the U.S. Virgin Islands, Puerto Rico, or other places, are we going to hear from them next week? In other words, are there other remote areas where there are Medicare beneficiaries in SNFs that we are going to hear from?

DR. ROSS: We hear pretty regularly from Puerto

Rico just trying to get the standardized rate up to the mainland rate, much less with a COLA.

DR. WILENSKY: But it's very different because the tax relationships are so different in the other areas.

DR. ROWE: What about those other ones?

DR. WILENSKY: I assume they also are going to have the same issues with regard to their taxes.

DR. DOBSON: It turns out I've studied the GPCI for Puerto Rico and very much the same kind of arguments are made, transportation, et cetera. But I think the tax relationship is real important. And the real argument there is the basic standardized payment amount, as was said.

DR. ROWE: With respect to Guam and the U.S. Virgin Islands, do we know anything?

DR. DOBSON: As I recall Guam and the Virgin Islands, on PPS at least, get the standard mainland rate, don't they, Joe?

DR. NEWHOUSE: Yes. I couldn't remember either.

DR. DOBSON: I think they do. You have to check that. But as I recall when I did Puerto Rico, one of the

things that folks continued to say is, how come the other guys get the average and we get our lower than average, kind of argument.

DR. WILENSKY: Whatever, they're going to be pretty small amounts of absolute dollars compared to Alaska and Hawaii.

DR. DOBSON: Yes. One thing I didn't say in my presentation is that the balance seems to sway a little bit towards Alaska. The feeling is that Alaska is a little stronger case than Hawaii.

DR. WILENSKY: I agree with that, but I feel a little uneasy about making the distinction when it hasn't been made before and when we're saying, we need to have more information so we know whether this is justified or not. So I would not be surprised at the end of the day if a study indicates it is either legitimate in one case, or certainly more supported in one case and in some question in another. I would personally feel more comfortable to make a distinction that does not now exist after the data rather than before. But again, I'm open to that.

MR. HACKBARTH: I support that recommendation, but just one question, Gail. What sort of information would be used for the study? What sort of data can we --

DR. WILENSKY: I actually liked what Al just --

DR. DOBSON: I threw out two ideas. One is we can take the existing inpatient cost per case, adjusted for length of stay and adjusted for full-time equivalents, to get rid of the quantity side, to make it a more pure price issue. And the second was, why don't we go to the source, the way HCFA calculated the data, pull out those per diems, and take a careful look at them?

DR. REISCHAUER: Isn't that data contaminated by the fact that we're paying them more? Didn't you say that there was an adjustment --

DR. DOBSON: I was going to look at -- these are the cost per case. Now you might argue because they got paid more, they get more.

DR. REISCHAUER: If you don't get paid for what you're doing, you stop doing it. So it has to, over time contaminate it.

DR. DOBSON: You may be right, the cost structure is a function of their income. But we made the judgment in '82 that their costs were higher then as well, by about 25 percent, and apparently those numbers haven't changed all that much.

DR. REISCHAUER: It won't because you give them 25 percent more.

DR. DOBSON: We've probably maintained the differential. Maybe we've maintained the differential they had when we started, which would be a little less --

DR. REISCHAUER: In a funny way, I think the right thing to do is to look at the production of other service products besides health and compare them, because what you do is so contaminated by how much you pay.

DR. DOBSON: What you find then -- I didn't mention this, but in rural Alaska, construction cost, et cetera, is like twice in Anchorage. It's amazing what's going on.

DR. REISCHAUER: You could end up with bigger numbers.

DR. DOBSON: That's exactly right.

MR. PETTENGILL: Remember that the COLA in the inpatient PPS applies only to 29.9 percent, 28.9 percent, so you're not going to contaminate spending too much.

DR. WILENSKY: Yes. I visited a nursing home above the Arctic Circle when I was at HCFA. I was impressed at some of the difficulties of getting to this, with a census of five, a nursing home in Kotzebue, Alaska. It probably makes me slightly more sensitive to some of the issues, especially in terms of relying on the bush pilots to get people around because there are no roads, and the difficulties of moving both people and products out to where these sites are around Homer and Port Arthur.

Are we ready to take a vote of combining? We'll start with one and three unless someone wants to have a proposal, of collecting information but maintaining the special payments.

All in favor of voting yes?

In favor of voting no?

All those who want to have a not vote recorded?

Thank you. We appreciate it.

DR. DOBSON: Thank you.

DR. ROWE: Since we mentioned Alaska I'm going to take one second and give you a very quick, recent Aetna Alaska story. We have a heroine in our company. I want to tell you about this since it's exciting.

We have the state of Alaska employees as one of our clients, and one of them was on the phone with a claims person from Aetna in Seattle trying to handle a claim problem that she had when the earthquake hit Seattle. And the person from Aetna took the phone, got under her desk, and resolved, adjudicated the claim with the Alaska employee. The guy who sold the case called me and said, Dr. Rowe, we're going to have that case forever. Those people will never go to another insurance company.

DR. WILENSKY: Thank you, commissioners. Thank you, Al and your colleagues. I will be in touch with the commissioners whose appointments are up. Again, thank you very much for all of your participation and help.

[Whereupon, at 12:31 p.m., the meeting was

adjourned.]