MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Crowne Plaza Hotel
14th & K Streets, N.W.
Washington, D.C.

Thursday, January 14, 1999

The meeting in the above-entitled matter convened, pursuant to notice at 10:28 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair

JOSEPH P. NEWHOUSE, Ph.D., Vice Chair

P. WILLIAM CURRERI, M.D.

ANNE B. JACKSON

SPENCER JOHNSON

PETER KEMPER, Ph.D.

JUDITH R. LAVE, Ph.D.

D. TED LEWERS, M.D.

HUGH W. LONG, Ph.D.

WILLIAM A. MacBAIN

WOODROW A. MYERS, JR., M.D.

JANET G. NEWPORT

ALICE ROSENBLATT

JOHN W. ROWE, M.D.

GERALD M. SHEA

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P R O C E E D I N G S

DR. WILENSKY: Julian?

MR. PETTENGILL: Good morning. The chapter is located at Tab A and you should have the copies of the overheads in front of you. I would like to apologize for the delay in getting this material to you. I hope you all had time to read it and read it carefully.

I want to keep my remarks brief this morning mainly because I want to give you plenty of time for comments and discussion. So what I'm going to do is give you a quick overview of the structure of the chapter; then I want to talk a little bit about the major design issues; and then I'd like to focus attention on two areas that I've been wrestling with in writing the chapter.

One is this issue of payment consistency across settings and the other is how I plan to deal with the conclusions or the wrap-up section of the paper.

Fundamentally, what this chapter tries to do, or I should say, what I'm trying to do here is to pull together in a policy framework many of the discussions you've had on a wide range of payment issues over the course of the last

year. The content is organized in six sections, but the meat of it is really in three of them. The section on objectives and environment identifies the key payment objectives and the challenges that policymakers face, including the Commission, in dealing with payment issues.

The section on design issues covers the six basic design decisions, the related policy options, then the key factors that should be considered in making choices among them. As I indicated in the draft, I plan to use the conclusion section to try to highlight the three or four main ideas that drive the Commission's consideration, in fact, I hope drive anyone's consideration of payment policy issues.

I'm trying to do all of this, however, without actually drawing conclusions. I would hope that at no time does the paper ever say, this is the way you should do it or this is the answer you should reach. It's not intended to do that. It's intended to identify what you should think about when you're trying to make decisions.

I also wanted to make you aware that if you look at the outline there, it says evaluating system performance.

I think that's an incredibly important issue, but I also think at this stage, given time constraints and the length of the chapter already, that if I were to include that, I wouldn't be able to do it justice and it could be a chapter all by itself.

So my plan at the moment is to drop that section, which is not to say drop the idea that you need to do this, but drop it as a separate section because it would add so much length, and I just don't have the time and mental energy to do that at this point. I think that's a very demanding topic, even more so than some of the others I've already tackled.

Now I'd like to turn to the design decisions. This section not only lays out the decisions you have to make, but it examines each of them using a set of illustrations and examples to highlight the kinds of considerations you have to take into account in reaching a conclusion about which of the options to pick.

Three of these decisions are largely fleshed out, as you've seen, and the other three will be treated very similarly, attempting to reflect what the issue is, why you

need to address it, and the alternative approaches that you can take to addressing it as reflected in your discussions in October, November, and December -- not so much November, but December and today and tomorrow.

Now I'd like to switch to focus on the two parts of the chapter that have been problematic to write. Perhaps I should add a third, which is the update. Payment consistency, I think, is particularly difficult to deal with because it doesn't really fit in the context of each of the other design decisions that you just saw.

It's a cross-cutting issue that arises whenever we have the same or similar products across settings, and dealing with it means it may affect the decision you make in many of the design issues for a particular system, but at the same time, it's something that has to be drawn together because it's outside individual systems. It operates across them.

So what I plan to do is to try to address it to a minimal extent in the discussions of each of the individual design decisions and then have a section following the design decisions where this is added as an issue, a seventh

issue, if you will, that you need to consider.

I have a pretty clear idea of how I want to write that, and I think the way I would do it is talk about, again, what is the issue here, why is it important, and then use three illustrations of different ways it comes up and how it might be addressed.

Ambulatory care, in a way, much as you've discussed that, is, in some ways, the simplest case because you have a unit of payment that is the individual service. The service is defined, or we hope it will be, essentially the same way in all settings.

That makes it relatively easy to deal with because what you have is parallel payment systems. They don't operate internally exactly the same way; in other words, the decisions about how the relative values are created and how the initial level of payment is determined and the update, to some degree, may be different, but they're all paying for the same thing and you can isolate differences in payment here. You can see them.

In post-acute care, you have a different kind of an issue. Here the major issue is, what is the unit of

payment that you ought to choose given that we have services that are provided in multiple settings and HCFA has already made a choice about the unit of payment in the skilled nursing facility setting, that is to use a per diem model.

The question is what to do about rehabilitation facilities where I think many people believe that the most appropriate approach would be a per-discharge system. So you have a conflict here that you have to address and it's much more difficult, I think, than the ambulatory care setting.

On the hospital inpatient side, you have yet another illustration of how consistency across settings may matter and also what you do about it, and that is the incentive to change the product, to unbundle services before and after the stay or at the beginning and the end of the stay and how you respond to that, both treating it in the update, treating it in how the relative weights or relative values change over time.

We have special rules, the bundling rule that says if it's an outpatient visit and it happens within 72 hours of admission, it's part of the stay. We have a transfer

policy that deals with the tail end of the stay. So that's a different proposition than the one we're facing in either ambulatory care or post-acute, although there may be elements of post-acute that get us to the same place, or at least force us to face some of the same issues as we're facing now on the hospital inpatient side. So that's what I plan to do with that one.

Regarding the update, which I hadn't planned to talk about, partly because I work one section at a time instead of trying to think about everything at once, and I haven't fully worked out exactly what I'll do with that, but clearly, we have different update approaches being taken in different sectors and they're both mandated under the law.

We have the sustainable growth rate approach in the physician fee schedule and we have the notion that you should take into account the factors that would be expected to affect a hospital's costs for the hospital updates.

My sense of how to deal with that is to be perfectly descriptive and say, this is what we have. We have two conflicting approaches to deal with this problem and they require you to think about different things,

without making a judgment about, at this stage of the game which I know you would be uncomfortable with, that one approach is the right approach and the other is the wrong approach or something like that.

That's a decision you may ultimately come to at some point, presumably for good reasons, but you're not there yet, I don't believe, and so the chapter will describe what those alternatives are and what you need to think about and leave it at that. That's what I plan to do.

Now, the last part that I think is difficult to deal with is the closing. It seems to me that this is a fairly long chapter and although it doesn't deal with the infinite detail at the lowest level of all of these policy issues, which would take a book, it's still long enough so that it's easy to get lost in it.

I think that it would be very helpful, if at all possible, to draw together at the end what the Commission thinks are the main ideas driving design, as well as some other ideas that surround design in the sense that design is one stage of a process. You have to do it. Once you've done it, then you're into a new phase where you have to

implement it and that raises a whole lot of issues that people need to think about even when designing the system.

So what I thought I'd try to do here is to bring up some basic ideas that I think at this stage are really driving, thinking about design, and one of them is that you have to fit the circumstances in each setting. That involves a bunch of things really. In fact, both of these principles, fitting the circumstances in each setting and balancing the payment goals against unintended responses by suppliers, are fundamental issues that are driven by the objective of setting market-like prices.

To fit the circumstances, you have to know the product and you have to have some reasonable level of understanding about the production process that goes into producing it. But in addition to that, you're always limited. There's a trade-off here. You're always stuck with the limitations in the short run of available tools and information.

Do you have a classification system that fits your understanding of the product and its production process? Do you have the data that you need to assign people to the

classification and to build relative values? Those are questions you can't avoid, so that's part of fitting the circumstances in the sector.

The other goal, the other principle of balancing goals with efficiency against the potential for unintended responses is also a very strong guide in system design. It seems to me that that involves two parts. First is within a setting. You have to, in trying to balance unintended consequences against incentives for efficiency, I gave you this brief description of something that I call creating manageable risk.

You have to put the provider, the supplier, in a position where, in a sense, you're not asking too much. The price is within the range, a range that the supplier can actually respond to without having to beat the system to do it.

But then outside the system, outside any particular settings, payment system, you have to also worry about limiting unintended shifts in services, which is what the consistency of payment is about.

So I plan to talk about those two things. And

then the other considerations involve the difficulty of doing this. To design a system and put it in place requires an awful lot and especially to do it well. You're often in a position where you're stuck with a second best and then if you're going to be stuck with a second best, the question is do you do it or not. Do nothing or put it in place?

If you do, then you'd better start worrying about the dynamics of reform because there's not only the initial implementation, but then there's subsequent revision that you have to worry about, and implementation and revision always cause redistribution of the money and as soon as you do that, you create resistance.

The last is really the importance of monitoring. There's a lot that can go wrong in response to a system and you really need to monitor what happens for two reasons. One is that you need the measures in order to figure out how to update the system over time, but in addition to that, you need the measures in order to evaluate what specific policies might need to be changed and to protect beneficiaries.

So perhaps the closing thought would be in the

end, when you're thinking about all these issues, the last question you ought to be asking is, does this work? Will this work for the beneficiaries or how will this work for the beneficiaries, because that's the ultimate intent of the program, is the beneficiaries.

DR. WILENSKY: Thank you for the presentation. Let me open it up. Gerry?

MR. SHEA: I thought this was a very useful idea doing this framework chapter, so I think it's the right thing to try to do. It obviously raises or it has the potential to raise, gee, aren't we making a statement of first principles here. But for my money, I thought the chapter, even as it stands now even with the gaps in it, was quite well done and I think it was particularly well done in stating plainly, trying to state plainly, and I think effectively doing that, the sort of framework issues here, you know, what does the architecture look like.

The one thing I found myself wanting to hear more about, and it was in the conclusion section, was the last point you made, Julian, which is, what is the bottom line here in terms of the provision of services for

beneficiaries?

I thought your opening paragraph set that up simply and nicely and then you went through, as I said, a plain statement of payment as opposed to very technical ins and outs kind of in the weeds discussion. I think at the end, if we could find a way to bring it back and root it again in the basic question here, are we delivering services the right way for beneficiaries, and maybe drawing that out a little bit.

So I would encourage you to try something in that regard, but I like what's here very much.

DR. WILENSKY: Could I ask you, Gerry, would you object to a slight modification just the very end of your statement, which is not so much are we delivering services the right way to beneficiaries, but have we designed a payment system that helps to get the services?

MR. SHEA: Right, that's a friendly amendment because that's what this chapter is about.

DR. WILENSKY: Yes, that is, that is. That's why I raised it. I thought you would not object to that. Any other comments about the material that we have before us?

DR. LAVE: Julian, I'm a little concerned about what you're going to include in the consistency aspect of it because it strikes me as being an important part. There are two issues. One issue has to do with the nature of the product and that has to do, when I have an inpatient episode, what am I going to consider to be part of that inpatient episode?

That's where it seems to me that the transferring issue and what happens 24 hours ahead of time belongs rather than the consistency issue. The consistency issue is one that strikes me as being one that a number of different provider settings provide services for which they are either similar or there's a considerable amount of overlap.

It's difficult to tell that the settings are -- to some extent, the products are unique, but if you thought about a Venn diagram, which might be a reasonable way to think about it, that there's a lot of substitution across these depending upon how the Venn diagrams overlap or how people can respond to what's going on.

We often don't know much about sort of what actually goes on in those settings and that's where the

rehab and the outpatient stuff comes. I think it might be useful to think of it actually in terms of a Venn-type diagram and that's really where the consistency is because if we knew we had the identical product, I think everybody would feel rather sanguine.

If you had an identical product, you would way to pay in an identical way, but we don't believe these products are really identical, and so the question is what do you really do about this overlap of what, in fact, is going on?

So one has to do with the definition of the product. The other has to do with sort of different kinds of products, and I thought the other thing, when you talked about the nature of the product and the episode, I'm back to the nature of the product, that even there, we have a very different way. We think about things differently and you may want to expand this a little bit when you say the unit of service for hospital inpatients or hospital stay.

But on the other hand, I could say to you the unit of service is a hospital stay and that should include all the services, in fact, that are provided, including the physician services. Not that I'm recommending that we do

that, but that we point that out.

The same thing when you think of the physician care can be an episode of care in individual service, I think you want to put something in that that's intermediate along that because that's really where we're going. Where if I say an office visit is a service, we could have very different ideas about what should be included in that. So there are various levels of sort of whose services are aggregated in this bundle of care, because those are really the issues, in fact, that we're struggling with, partly on the hospital outpatient side. I still have the sense that there's some bundling going on that we don't quite understand.

So I think that that would help because we're trying to figure out who to put together and then obviously eventually put everything together in one payment, which I think takes us back. But the inpatient care one is not so simple.

We made a decision about what would be included, but that's not obviously a decision that would be made in England because in England, all the physician stuff would be

in there even if you were doing it or in a veteran's hospital. So it's just some little elaboration because I think it's useful for us to come back to the issues that are raised here and these are some of the problems that we struggle with later on.

DR. NEWHOUSE: Julian, I thought what was here was nicely done. So this is more on what isn't here and some suggestions on how to set it up.

First, kind of a minor point that will lead me into my more substantive point. You say on page four that we're striving to establish the payment rates that approximate the competitive prices that would prevail in the health care market. I think you ought to make some reference to hypothetical or something since there's a lot of people that are skeptical that left to it's own devices, the health care marketplace would yield competitive prices.

But that actually leads me on to my second point, which I think is, competitive prices would bear some resemblance to costs, and in fact, in a perfect world, they would be marginal costs. I don't know if you want to, at this point, get into the average marginal distinction, but I

think that sets you up then for emphasizing a couple of points.

One is that to the degree you pay differently from cost, you have two potential problems. One is, you have a selection or creaming or dumping problem. That I found actually under-done here. It surfaces in the text at a couple points, but it's not actually broken out as a major heading on a parallel with the others. So that's one issue.

The second issue about paying differently from cost is either over-provision or stinting and you do say something about stinting, but not really over-provision. Then maybe you want to say just about carried to an extreme, you would price every little service, but the more you try to price every little service, the more error you're going to make in trying to get cost because it's just too hard. That's a suggestion for you to think about in terms of how to set the thing up.

In terms of what could be here that wasn't, I would have liked some discussion of outlier features of a payment system.

MR. PETTENGILL: I plan to put that in.

DR. NEWHOUSE: Good.

MR. PETTENGILL: In fact, I was planning to do it in the other payment adjustments section because that's where it is.

DR. NEWHOUSE: Okay, fine. And in the monitoring and evaluation thing -- this is the researcher in me -- if our uncertainty is large enough about what we're going to do, the usual approach in practice is to tip-toe in with some sort of phase-in and then if things really start to go awry, maybe we stop. I'm not sure this was the reason why we did it, but we added an extra year to the PPS phase-in.

MR. PETTENGILL: I don't think that was the reason either.

DR. NEWHOUSE: But one thing that occurred to me is if the uncertainty is great enough, one could give some consideration to holding out a few areas as, in effect, a control group that would give you a better sense of what, in fact, the policy was. It would just give you more confidence that you had a handle on what you were doing.

If you're confident enough, then go ahead and implement it, but it seemed to me that for a chapter that

was to be a kind of conceptual overview, we ought to include that as a possibility.

DR. KEMPER: I, like others, thought this chapter was really excellent and actually shows some of the benefit of combining the predecessor commissions in the perspective that it provides.

One general comment just following up on what Gerry said in terms of the importance of adding something about monitoring. I think it would be useful to talk about feedback signals that tell us when the rates are set incorrectly. The most obvious place where that comes up is with the updates and what do you look at that's sort of a general level of payments, and the difficulty of getting the information to do that even figuring out what you want to look at to decide whether or not it's way off or a little bit high or a little bit low.

But it also applies to other kinds of relative values and so on and relative setting, relative rates across settings of how do you decide when the rates are off.

A couple of more specific comments. I thought one of the strengths was bringing in the Medicare+Choice and

setting rates for risk payments. I would push that even further in weaving that into the discussion and in some of the examples.

MR. PETTENGILL: I'm a little leery of that because I think sometimes -- I mean, if you really look at the way the payments are set, I think it would be hard to do that, to use that illustration without begging conclusions.

DR. KEMPER: Well, I flagged a couple of places in the text where it might be possible to do that, where I think really the issues are, at least at the level of this framework, identical kinds of issues that would be addressed.

Another specific comment is that you place a lot of emphasis on the production process in defining units and defining elements. I think it's not only the production process, but also clinical meaningfulness of the unit or the diagnosis or whatever, this sort of clinical perspective on how you pay is important, at least in certain kinds of things.

MR. PETTENGILL: I don't see them as being disconnected.

DR. KEMPER: Right, it's just bringing out the clinical side as well as the production side because they're not necessarily one-for-one.

The last thing has to do with your slide of fitting the circumstances to the setting. I think of it more as fitting the circumstances to the service rather than necessarily the setting, and this has to do with our discussions of substitution across settings and so on, or at least maybe it's fitting to the circumstances of each service and setting.

MR. PETTENGILL: I regard that as one of the circumstances of the setting is what is the nature of the product and the production process. That's part of it. So when you make your system fit those circumstances, you're automatically taking care of that and I would write it that way.

DR. KEMPER: But I think it's also the fact that what the nature of the services also has to do with whether it's substitutable across settings, whether or not many of the issues you raise apply or not have to do with the circumstances of the service as well as the settings.

DR. MYERS: I'll try not to repeat what others have said. I, in general, thought the framework was very well developed, but I wish there had been more discussion of the interactivity between what happens in a Medicare patient population and the other patient populations that a provider cares for. If you've got a practice or facility that's 40 percent Medicare and 60 percent Medicaid, you look at it very differently than if it's 60 percent private pay and 40 percent Medicare.

I would have liked to have seen the setting definition expanded and the context looked at with respect to who the other patients were as opposed to a more limited view just of what happens within the Medicare prospective payment.

MR. PETTENGILL: That's a tricky issue to deal with, I think, because it is a consideration, sort of what the business as a whole looks like and how it varies among suppliers or even among market areas, is a consideration sometimes in designing other payment adjustments to try to reflect the implications of those differences for suppliers' costs.

DR. MYERS: It's much easier to cost-shift against the Ford and GM than it is to cost-shift against the state Medicaid program of Indiana, so what one thinks about therefore behaves differently.

MR. PETTENGILL: Some of that, I think, will come out in the discussion of other payment adjustments because that is one of the considerations. But that's also one of those topics that one could go on about at great length.

DR. MYERS: I wouldn't propose that. I would propose mentioning a little bit more than you're got.

MR. PETTENGILL: Okay.

DR. CURRERI: I also enjoyed this chapter. I think it's very thoughtful and I think it helps put the chapters that follow in perspective.

I have one question on page 15 where you were talking about how to define the product, and you talk about clinical factors that need to be looked at, at the service, patient, or beneficiary level. I was trying to figure out what is the difference between a patient and a beneficiary. I was sure you were trying to say something there, but I didn't quite get it.

MR. PETTENGILL: Yes, I did have something in mind. At the patient level in the hospital setting, we define a case, a type of stay using a set of clinical factors to do that. But at the beneficiary level, we define the risk, the riskiness of the person based partly on clinical factors, but they're not necessarily the same ones that we would use for a stay.

We ideally would be thinking of what's the health status of this person as measured by clinical information available for multiple settings or even all settings.

DR. CURRERI: So maybe you should say inpatient or inpatient and outpatient.

MR. PETTENGILL: Sure, I could. All right.

MR. MacBAIN: Julian, I too think this is a very useful way to lead off the March report to sort of make explicit what we've all thought we've been doing, but it really helps to see it laid out in an orderly fashion. I think it's going to be useful as we go back and go through a few more iterations of this.

One thing that several people have touched on, and you do as well in the chapter, but not as explicitly as I

think I would have is the behavioral aspect of this; that in a market where one payer is so dominant that it can put out administrative prices and expect a reaction as a result of that, we talk a lot about trying to speculate how producers will react.

If there's a differential based on settings, will that result in a shift of services from one place to another? It's a behavioral phenomenon. Similarly, will an increase draw more producers into the market? Will a decrease result in restricted access to beneficiaries?

It's something that we spend enough time speculating on with all of these that I would include it in your list of major design issues as an explicit point.

MR. PETTENGILL: Well, I think it's something that clearly affects the design decisions that you make and how you think about them, but it's not a design decision itself. Right?

MR. MacBAIN: Well, maybe so, but as we go through looking at these things, we'll talk about the various components you have listed here and then sort of step back from it and say, now how are people going to react to this.

MR. PETTENGILL: Right, exactly, and in fact that's what I was trying to convey, is that in some of these decisions, that is a major consideration and it ought to be.

MR. MacBAIN: This may be anathema to economists, but it's as much psychology as economics.

MR. PETTENGILL: Yes.

DR. LONG: Julian, I too was delighted to see this chapter, very pleased that we're going to be including it. I've got a couple stylistic and technical notes that I'll give you later.

The one substantive thing that I wanted to raise was with respect to perhaps in the area of page 15 where we're talking about how well we can define the product. In general, we seem to spend a lot of time here talking about costs and efficiencies in the sense of minimizing input for a defined output, and we don't spend very much time talking about the output in the broader context.

Historically, we've not been able to do this very well because we just haven't had the data, but I think increasingly we will, to talk more about the output side and particularly differences in quality and outcome.

You can have two providers of equal cost and equal volume with very different outcomes even if you control for the risk associated with the beneficiary or the risk of the patient or the risk of our current categories or products.

There's also a huge risk dimension here in terms of variability of what different providers, in fact, produce in terms of the outcomes. I think we should at least foreshadow that as a major issue that will probably become more major as time passes as we get a better handle on figuring out how to measure in an objective way those kinds of differences.

MR. PETTENGILL: Needless to say, that's a really difficult issue, but I'm happy to raise it.

DR. WILENSKY: Julian, now that you've had about nine suggestions about what to add to it, let me caution you that it's an introductory chapter and I think if it's going to serve the purpose that you and we intend, you'll have to use some discretion about how to try to raise some of the issues the commissioners would like to see raised without getting into discussions that mimic what should be in the individual chapters, so that we don't lose the sense of both

setting a framework and tying the issues together.

You will be in the best position writing that, and going back to look at what you've done to see how to balance those forces.

MR. PETTENGILL: I think in many cases, it's a matter of adding a paragraph that raises the issue.

DR. WILENSKY: Sometimes maybe literally adding a sentence in reference so that you can alert the reader that this is an issue that we understand is important, but will be dealt with in the chapter, or whatever. Anyway, just to urge caution that it will lose its effectiveness if it grows too much in size.

MR. PETTENGILL: Right.

DR. WILENSKY: Thank you. We are going to go to the next section and switch the order that was initially presented in the agenda, doing the risk adjustment phase-in options first and then the Medicare+Choice recommendations. Dan, Julian?

MR. ZABINSKI: Okay. HCFA has indicated that it likely will phase in the new risk adjustment system over several years in response to concerns that Medicare+Choice

organizations will either leave Medicare+Choice or alter the market areas they serve because the new risk adjustment system may reduce the payments that the organizations receive.

Today I'm going to discuss and compare two general phase-in methods, corridors and blends, and then I'll turn it back over to the Commission so they can discuss phase-in further and determine any phase-in recommendations they would like to make for the March report.

Now, both the corridors and blends would mitigate the effects of the new risk adjustment system, but a corridor is a boundary around the annual percentage change in per-enrollee payments due to risk adjustments. So what a corridor does, it puts an absolute limit on the effects that risk adjustment can have on an organization's payments.

Now, in contrast, a blend only softens the effect of risk adjustment by taking a weighted average of the current and new effects or the effects of the current and new risk adjustment systems. This is a direct result of the method for determining payments under a blend where you blend or you determine payments by blending the enrollee

level payments that would occur under the old risk adjustment system with those that would occur under the new risk adjustment systems.

Now, to give you a general idea on how each of these two methods would work, I'd like you to consider the following diagram and I really want to stress here that everything here is hypothetical. Okay?

Now, what I've assumed here is that I have an organization that has a per-enrollee payment under the current risk adjustment system in 1999 of $500. This organization is in a county that has a 2 percent rate book update every year. The organization has the same enrollee mix in 1999 through 2003 and the effective risk adjustment on this organization's payments is 8 percent.

Now, the first row of the diagram shows the per-enrollee payments for this organization in 1999 through 2003 and the second row is just the payments that would occur under the new system for this organization in 2000 through 2003.

The third and fourth rows demonstrate the effect of a hypothetical four-year blend phase-in where the pairs

of numbers in row three are the weights that would be used to determine the payments under the hypothetical blend, where the first number in each pair is the weight that would apply to the payments under the new risk adjustment system and the second number in each pair is the weight that would apply to the payments under the current system.

The fourth row is the payments that would ultimately occur under the blended phase-in where the thing to get out of this, I think, is that as you go through time, the difference between the payments under the blended system and the payments under the new risk adjustment system without a phase-in gets smaller until ultimately in 2003, there is no difference, indicating that risk adjustment has been fully phased in.

Now, the final row shows the payments that would occur under a corridor where in the year 2000, the effect of risk adjustment is limited to be 2 percent and the limit of risk adjustment in each following year is increased by 2 additional percentage points, meaning that in 2001, risk adjustment can have an effect of no more than 4 percent, 6 percent in 2002, and 8 percent in 2003.

Now, because the effect of risk adjustment without phase-in is 8 percent, the effect of risk adjustment is restricted in the situation in 2000, 2001, and 2002, meaning that the payments under the corridor are greater than what they would be under the payments under the new risk adjustment system.

But in 2003, the effect of risk adjustment is not restricted, so the payments under the corridor or under the new risk adjustment system without a phase-in are the same, indicating that risk adjustment has been fully phased in.

DR. CURRERI: Can I ask a question before you go on? Did you run the same simulation with the plus 8 percent rather than a minus 8 percent and do you get comparable increases over the simulation?

MR. ZABINSKI: No, I didn't run it. Let me think about it for a moment.

Yes, you get generally the same idea, I would think. It's just that the numbers would be going up. They'd be a little higher through time, but generally it would be the same thing.

In order to determine which of these methods is

the preferable method, I believe there are some key issues that need to be considered in order to make that determination. Now, I think the most important issue to think about is what is the primary objective of the phase-in in terms of how it affects payments.

Now, if the primary objective is to put a definite limit on the effects that risk adjustment can have, a corridor is better. However, under a corridor, your time is always -- well, is a strong consideration because if you consider an organization that would have their payments strongly affected by the new risk adjustment system, under a corridor, it may take a long time to phase in risk adjustment for such an organization.

Now, in contrast, if the primary objective of phase-in is to soften the effects of risk adjustment and to let organizations ease into risk adjustment over a fairly short time frame, then a blend is probably the better method.

A third issue to be concerned about is how the methods differ in terms of the incentives to, first of all, for organizations to risk select and second of all, the

incentives for organizations to increase the rate at which they hospitalize their enrollees.

A final issue to consider is the ease of implementation of the two methods. These next two slides provide a comparison of the two methods in regards to these issues I just discussed.

Now, in regard to the effects on payments, a corridor places a definite rigid limit on the effects that risk adjustment can have on payments, but a blend does not. However, under a corridor, an organization that would not have their payments restricted by the corridor -- in other words, they're within the corridor -- would have the same payments under the corridor as they would without a phase-in. But a blend softens the effect of risk adjustment for all organizations.

Now on a related point, because the methods would affect payments differently, the effect that the two methods would have on the cost of the Medicare+Choice system would differ as well.

Now, a second issue to think about is the fact that the new risk adjustment system will reduce the

incentives for organizations to risk select, and under a corridor, an organization with a payment change that is within the corridor will have the same incentive to risk select under the corridor as they would without phase-in.

But an organization where the payment change is restricted by a corridor will have more incentive to risk select under the corridor than they would without a phase-in because if you consider this situation of an organization, if they selected better risks, their costs would go down as would their payments.

Now if the same organization did the same thing under the new risk adjustment system without a phase-in, their costs would go down by the same amount, but their payments would go down by a larger amount.

Now, under a blend, any organization that selects better risks will reduce its costs and its payments, but if the organization once again did the same thing under the new system without a phase-in, once again, the costs would go down by the same amount, but the payments again would go down by a greater amount. Therefore, under a blend, all organizations have more incentive to risk select under the

blend than they would without a phase-in.

Now another issue focuses on the fact that the new system may provide an incentive for organizations to increase the rate at which they hospitalize their enrollees. Now, under a corridor, this incentive might be reduced for organizations with their payments that are restricted by the corridor. For example, an organization with a loss that is limited by a corridor will not increase its payments by increasing hospitalizations unless the increase in hospitalizations is enough to increase the organization's payments so that the organization is at least at the lower limit of the corridor.

Now, under the blend, an organization that increases its enrollees hospitalizations will increase its costs and its payments, but if this organization did the same thing under the situation of the new system without a phase-in, its costs would go up by the same amount, but its payments would go up by an even greater amount.

Therefore, under a blend, all organizations have less incentive to increase enrollee hospitalizations with the blend than without a phase-in.

Now, a final important issue is that a corridor likely would be more complicated to implement than a blend. Under a blend, you simply have to combine the enrollee level payments that would occur under the new system with those that would occur under the current system and you're finished. There is no more work to be done.

But a corridor might be more complicated for two reasons. First, in determining an organization's aggregate payments, it would require that HCFA know the effects of risk adjustment at the organization over the whole year. But because enrollee mixes change for an organization throughout a year, HCFA could not know that information until the end of the year. Therefore, HCFA likely would have to make an estimate of the effects of risk adjustment at the beginning of the year and then make any necessary payment adjustments at the end of the year.

A second reason why a corridor might be more complicated is that in order to determine payments under the corridor, the effects of risk adjustment need to be separated from other factors that might affect payments such as enrollee mix.

Now, in closing, there's also a final possibility as far as the phase-in method is concerned, is to mix the two methods where the payments under the current and new systems would be blended, but the percentage change in aggregate payments per enrollee would be restricted as well.

This would soften the effects of risk adjustment for all organizations which a corridor does not do, and would also put a firm limit on how much payments can change, which a blend does not do. It would also preserve some of the reduced incentive for organizations to risk select as occurs under the new risk adjustment system and would also reduce the incentive for organizations to increase the rate at which they hospitalize their enrollees.

That concludes my discussion for today and I'd like to turn it back over to the Commission so that they can discuss any phase-in recommendation they might want to make for the March report.

DR. WILENSKY: You may not be able to answer this question, but in the phase-in for the relative value scale, was that not a blend? Is that a blend and a corridor?

DR. CURRERI: Yes, it was a blend.

DR. WILENSKY: Wasn't there a limit?

DR. CURRERI: No, no corridor, just a blend.

DR. WILENSKY: Wasn't there a limit? I thought there was a limit on the amount of change.

MR. HAYES: There was a limit in the first year of 15 percent.

DR. WILENSKY: So at least for the first year, there was a blend and a corridor.

MR. HAYES: Right.

DR. WILENSKY: Just to try to get some idea. It sounds like, you know, how many combinations and permutations can we make, but that was my recollection, is that we actually did that for the first part of the relative value scale, so there is even some precedent.

MS. ROSENBLATT: First, I just want to mention that any comments that I make about risk adjustment -- and this particularly refers to Ted -- just remember that my particular organization has very few Medicare risk members.

I just want to compliment the numerical examples. I thought that having the different scenarios and working out some of the numerical examples was very well done. I

also -- and I can't tell you why, but I would sort of be in favor of a blend with a limit, but if you're doing both, I would say the numerical limit should be larger than if you were just doing the corridor.

It sounds like that's been done before, and that would also follow some typical actuarial types of analyses where a credibility approach is done. A credibility approach is like a blend, and then there's a catastrophic adjustment like co-pooling. So a lot of actuarial things use those two things.

I had a little bit of difficulty in terms of wanting Commissioner input on tone of this, if this does get into the final chapter, the comments about risk selection and hospitalization. I guess I have a hard time feeling that most managed care organizations have a direct link with their providers to be able to say that the risk adjustment is going to cause increased hospitalization, particularly when it's a prospective method.

And then to further go on and say that the phase-in will affect the risk selection or the behavior in terms of hospitalizing or not hospitalizing. I just thought that

was stretching it a little bit too far in terms of the tone.

One other comment, actually two other comments. The corridor, in terms of it being a back end adjustment, I've mentioned in the past, I always have problems with the back end adjustment and leaving the possibility for surprises to the organization at the end, so you may just want to add that.

And then I may have this wrong, but I thought the plan right now is for HCFA to add ambulatory services to the risk adjustment mechanism in a three-year time frame, which might say that a three-year phase-in might make more sense than a four-year, just so that you're sort of there by the time you add the ambulatory care.

DR. WILENSKY: One of the things that the staff might consider in the presentation is to be clear about what the incentives of the system are to do and whether or not it actually happens involves issues about the extent to which institutions can influence the physicians and the extent to which they would actually want to do that even if they could, but to lay out what is clear is that the incentives inherent in the reimbursement system are to do such-and-

such, so as to indicate that.

We're not saying that this will happen or probably will happen, but the incentives of the system are to drive in this direction.

DR. LONG: Could I comment on that particular point? I'm not at all convinced that there's any incentive to hospitalize here as I understand it. Quite aside from the separation between the people who are designing and marketing the plan and the people who are making the hospitalization decisions, it just doesn't seem to me to make any economic sense on a prospective basis. It's like pricing below variable costs. It doesn't work as a way of driving people from the market and never recovering where you were, and particularly if you're not the only plan in the service area.

All you need is one or two people to change plans and you've blown the whole potential, if there is one to start with, in terms of what extra rate you'd get next year for that person compared to what you actually had to pay out this year for the actual hospitalization. So I don't think that incentive exists unless somebody can convince me to the

contrary.

MR. PETTENGILL: Actually you should, when you read this paper, the background for this is Chapter 2 of the report. If we put something in about phase-in in the report, it will go into the section on risk adjustment in Chapter 2, which makes the point that the incentives are different from the expected behavioral response for a variety of reasons, which we enumerate in the chapter.

MS. NEWPORT: First of all, I thought the chapter was very helpful to me in understanding the differences, and maybe in the interest of full disclosure following on my esteemed colleague's example, I represent a very large managed care blend. Those of you in the audience who are surprised at that, raise your hands.

But this was very helpful and it helped me with my sort of analysis of this. What I'm concerned about is that tomorrow somewhere around 4:00 o'clock, HCFA will announce exactly what they're going to do and you may need to adjust this appropriately for that. They could blend it. You need to blend it a little differently, exactly.

I think part of this may be an opportunity, not

being aware of what they're going to do precisely, but having heard the rumors, that maybe it would be an opportunity then to make this as a more direct comment on what HCFA's proposal actually entails. So that's a suggestion.

Then I would like to also align myself with the previous comment which has to do with, to me, somewhat of a disconnect between perceived reaction in the market as opposed to what will really happen. To me, it's a little off center in terms of what, given my knowledge base with my operations, exactly what we would be able to drive.

Given the size of our organization, it's a little bit like trying to stop a super-tanker on a dime. It doesn't happen. These things change more subtly and then the changes are accelerated over time.

So I think that we're not and no one's in a position to be fully predictive of what the impact will be. So that part of the tone, I think, was problematic to me.

DR. NEWHOUSE: First of all, there is some textual language in the prior chapter about a phase-in that we probably want to try to come to a recommendation or not come

to a recommendation, as the case may be depending on what kind of consensus we have, but promote that to a recommendation if we have consensus.

As I've listened to the debate, I guess I have three kinds of issues to raise. One is, as I understand it, HCFA says they cannot do both, a phase-in and a numerical limit because of systems reasons. This seems a little hard to believe, but they know their systems better than I do.

Anyway, I think our discussion should be premised on the notion that we don't have the option of saying do both so that we're having to choose.

DR. WILENSKY: No, I think we ought to recommend what we think is better and then say it's our understanding that --

DR. NEWHOUSE: Whatever, fine, fine. But in any event, for determining -- we're going to have an influence on what will happen, we ought to assume that -- we can't just stop with saying do both and be done.

As I hear this debate from my friends in the plans, there's two first-order kinds of issues. One is obviously the money on the table and that risk adjustment

will pull money back from the plans. There is the issue that one could contemplate doing this in a budget-neutral way and maybe we ought to have some discussion of that, although that doesn't, I think, go to the phase-in versus the corridor issue.

The other issue people have already talked about, which is the incentive to hospitalize in an inpatient only system and I agree with Hugh and whoever else, Alice I think, said that because of prospectivity and the one-day stay rule and the degrading of the discretionary diagnoses or vague diagnoses, that there probably isn't much, if any, incentive to hospitalize left. I would have said this also dilutes the good side of what we're trying to do with this system, but for better or for worse, we've diluted both the good and the bad.

But the point I was going to make that relates to phase-in versus corridor is that it's much easier to generate evidence on what this system is doing on the incentive to hospitalize in a phase-in world than in a corridor world, because there's a kind of clean incentive operating on everything in the phase-in world, whereas in

the corridor world, there's the what did you expect. Did you expect to be over the corridor, under the corridor? If you expected to be over the corridor, there's no incentive because at the margin --

MR. PETTENGILL: You get little notch effects.

DR. NEWHOUSE: Yes. In that sense, I think one of the issues will be how long do we live with or have to live with this system and I'm not optimistic that in three years, we'll be in a position to kind of go full bore without patient data, but it would be nice if we were.

The issue of whether there are bad things happening on the hospitalization front is, in fact, important to know about or to get as much early warning about as we can and that a phase-in would do that.

Now, both the budget neutrality issue and the degree of phase-in obviously affect the overall hit, so that one can accomplish some of what one would get with the numerical limits or the corridors by tuning the degree of phase-in and whether one goes to budget neutrality.

Anyway, what I would say about this chapter is that one of the benefits you get for phase-in is that you

get a cleaner read on what the incentive to hospitalize is.

MR. MacBAIN: On the corridor question, maybe this is something that Alice, as an actuary, can shed some light on as well, but from a number of years of budgeting for health plans, a corridor does have the added aspect of reducing the unpredictability that is still present with the blend, particularly on the downside for plans that are sort of on the borderline of what to do.

Reducing the unpredictable negative effects could have a positive influence in keeping plans participating.

Also, in talking about the technical aspects of this, you talked mostly about the difficulties with the corridor and came awfully close to saying it's really not feasible. I'd be interested in your -- if you'd care to take that last, what is your opinion about is it really doable given the complexity of making it work.

MR. ZABINSKI: I wasn't trying to give the idea of any impossibility. I was just trying to get the idea that it's probably going to be more difficult and that's all I was trying to say. How much more difficult, I really don't know.

MR. PETTENGILL: Actually, if HCFA says they can't do both, I wonder how they can do a corridor at all.

MR. ZABINSKI: I was wondering that, too.

MR. PETTENGILL: Because if you can do a corridor, then you ought to be able to do both, logically.

MR. ZABINSKI: Right.

MR. PETTENGILL: But it is a lot harder. You have to accumulate information over the year. That wouldn't be that hard to do because HCFA is notified about every enrollment and every disenrollment. All they have to do is maintain the file. It's more difficult for the plan to know what they're going to get, whether they might end up at the end of the year having to return money, which is I think what people really dislike and not knowing in advance how much of a risk that would be.

MR. MacBAIN: But if you're returning money, it's because you're on the upside.

MR. PETTENGILL: That's true.

MR. ZABINSKI: That's right.

MR. MacBAIN: So if you're doing -- if you budget at the corridor and then reserve anything you receive in

excess of that, it won't be the nasty shock that other kinds of retroactivity can be. It's at least, I think, worth looking at, of whether this does introduce some predictability.

The third question is dealing with what Joe was talking about on budget neutrality, which gets a little bit beyond this. But does anybody recall if in scoring the Balanced Budget Act, if there were savings imputed to the risk adjustment part of that?

MR. PETTENGILL: Amazing that you should ask.

MR. MacBAIN: Because if so, then budget neutrality is already gone.

DR. ROSS: Actually some of us have a memory of that. It was not scored at the time of enactment, but the issue now in terms of, at least for Congress, is whether, in fact, to take action, whether it's included in the baseline and that's not clear at this point because CBO has not released their baseline.

DR. WILENSKY: That would then say that even the phase-in would be -- any phase-in would be a cluster if they include it in the baseline?

DR. ROSS: Preventing it -- yes, if it has to be done legislatively then there would be a cost attached to it.

DR. WILENSKY: Even if there was no saving initially included?

DR. ROSS: That's correct.

DR. KEMPER: Two questions. One is, do we have any evidence on what the distribution of the changes in payment rates will look like or even what the average would be?

MR. ZABINSKI: Yes.

DR. KEMPER: So we have some idea of what the average is.

MR. ZABINSKI: As far as the distribution, I'm not aware, no.

DR. KEMPER: Because I would think about this very differently if you said --

MR. ZABINSKI: Yes, that's a key variable right there, the distribution.

MR. PETTENGILL: We will know, presumably, as soon as HCFA releases that information, which may well be

tomorrow.

DR. KEMPER: I see, okay.

MR. PETTENGILL: And that may account for part of why they're releasing it at 4:00 p.m. in the afternoon. You can draw whatever inferences you like.

DR. KEMPER: The other question I have is, you alluded to changes in enrollee mix and you're sort of saying, assuming a constant enrollee mix, here's what the effect of corridors would be. I got the impression that the enrollee mix part was a sort of technically difficult part in implementing, but I didn't understand that.

MR. ZABINSKI: It's just the point that if you change the enrollee mix, you're going to change the payment that the organization gets, and the idea here is just to focus on the effects of risk adjustment on payments. So I just wanted to eliminate these other factors that affect payments and focus in on the effects of risk adjustment itself.

DR. KEMPER: So that's why then HCFA has to accumulate this information on enrollee mix every year is to deal with that?

MR. ZABINSKI: Exactly.

MR. PETTENGILL: If you want to phase in risk adjustment, then you want to isolate to the effect of risk adjustment itself and not changes in enrollee mix. So you have to tease the two apart, which is not hard to do in the blend. Blend does it automatically.

DR. KEMPER: Right, I understand.

DR. CURRERI: You talked about the incentive to risk select if you were outside the corridor, and I assume that that incentive would only be if you were below the corridor, that is that you had already risk selected, so the incentive would be to risk select even more to healthier patients so that you would --

MR. PETTENGILL: Reduce your costs.

DR. CURRERI: -- reduce your costs. Now, does it stand that if you are on the other side of the corridor, that you would then seek sicker patients? Would there be an incentive for that or not?

MR. ZABINSKI: Not that I can see.

DR. CURRERI: Up until the year 2003, there would be an incentive, would there not?

MR. PETTENGILL: No, you wouldn't take sicker patients because if you're at the upper corridor or above, taking sicker patients will not raise your revenue.

MR. ZABINSKI: Right. They'll just raise your costs.

MR. PETTENGILL: It will just raise your costs.

DR. CURRERI: But the following year, would it not result in a greater amount of money?

MR. PETTENGILL: I think if I were the plan, I'd wait until the following year. I mean, it would, yes, but why would I bear the cost now and get less revenue than I know I need for this year?

DR. NEWHOUSE: To be clear, if you're on the other side of the corridor, so the corridor is binding on going down, the incentives to risk select remain the same as they are now.

MR. ZABINSKI: Right.

MR. MacBAIN: If you're above the corridor.

DR. NEWHOUSE: Yes, but relative to the blend, which doesn't stay the same.

DR. CURRERI: But if you were above the corridor,

what would be the incentive there?

DR. NEWHOUSE: It's unchanged from the present because your revenue is fixed.

MR. MacBAIN: If you're getting paid at the top of the corridor, your costs are up here if you've got adverse selection.

DR. CURRERI: Okay, I understand.

DR. NEWHOUSE: That's at least within each AAPCC category.

DR. WILENSKY: Julian, excuse me.

MR. PETTENGILL: Well, do you want to have some discussion of --

DR. WILENSKY: Well, I think it's hard to do without going through the Medicare question. The difficulty is going through the Medicare+Choice recommendations and that's what I didn't know.

MR. PETTENGILL: Do you want to do it then? That's fine.

DR. WILENSKY: Maybe just stay up or stay close by or something.

MS. THOMAS: Good morning. Before we get started,

I wanted to apologize for a few glitches in the draft that we sent you. We noticed later that the pie chart, the percentages didn't match the slices and that I got a little sloppy with the cut-and-paste on the final section, but those have already been fixed.

First of all, I just want to review quickly the four potential recommendations for this chapter, Chapter 2. The first two recommendations were in the last draft of the chapter and they are certainly still on the table, but we haven't planned for much presentation of those two since it's sort of old news.

Since you've decided to defer the discussion of the risk adjustment phase-in, we'll bring that back to you after Scott has finished the discussion of the final recommendation which is something that you asked to be included in this draft on service areas.

Scott's going to provide some more information to you on this topic and if you still have time left at the end, you may want to discuss the final section of the chapter, which is new to you, on the goals for the program and measuring the results.

As always, editorial comments are welcome and we'd be happy to take up all marked-up drafts. Scott?

MR. HARRISON: Even though the second recommendation is a broad recommendation that HCFA try to be flexible in its dealings with Medicare+Choice organizations, the staff did perceive that you wanted an extra recommendation on the flexibility and service area design, so we're going to look at the fourth one.

The issue arises because Medicare payment areas do not usually match service areas. Payment areas are counties and service areas are often multi-county areas or are completely independent of county boundaries.

In past years, plans addressed the mismatch with flexible benefit packages. A plan would file an ACR for its basic benefit package for its whole service area and it could then flex up from that package with either lower premiums or higher valued benefits in parts of the service area. Presumably those parts would be the higher paying parts.

A provision in BBA does not allow for flexing up. Instead, as a transition policy for 1999, HCFA has allowed

plans to segment their service areas along county lines. A plan must submit a separate ACR for each segment and each segment may have its own benefit package.

On the next slide, you'll see side-by-side pie charts and you can see that there's a much greater share of plans that use the flexible benefits approach than are now using the segment approach. There are a couple possible explanations for that. Plans may find that it's too burdensome to file multiple ACRs, it's just not worth the trouble.

Also, HCFA may have discouraged segmentation by labelling it as only a one-year transition policy and through the language detailing the service area approval process that appeared in last June's preamble to the Medicare+Choice rule.

On the last page of the handout is a table that I hope will be useful in discussing this recommendation. It will take a little while to describe this table. We looked at the 118 multi-county metropolitan statistical areas that have at least one plan in at least one of the counties of the MSA.

We defined rate variation in the metropolitan area as the +Choice payment rate in the highest rate county divided by the rate in the lowest rate county. For instance, if you have a situation, say, in the Washington metropolitan area where Washington, D.C. was $600 and Montgomery County was $500, then the variation would be 20 percent, or as a ratio, it's 1.2.

We also divided the metropolitan areas into two groups, one that had at least one plan that had more than one segment in the metropolitan area, and the other group that didn't have any multi-segment plans. It turns out that out of the 118, only 24 actually had multi-segment plans.

Now, the numbers in the table are the percent of the metropolitan areas that have at least one plan in all of their counties. So, for example, the 83 in the last column means that 83 percent of the metropolitan areas that have low rate variation and no multi-segment plans do have plans in all of their counties. So, in other words, those metropolitan areas are sort of fully covered.

Now, the table suggests two things. First, plans are more likely to exist in all parts of the area if the

rate variation is lower, and that makes some sense. And second, plans are more likely to exist in all of the counties of the area if there are plans there that segment. Does anybody have any questions on that?

MS. THOMAS: So at this point, we'll turn over discussion of all four recommendations back to you.

DR. WILENSKY: Why don't we take these one at a time? The first one is on page two and we have two recommendations.

The first one, as has been indicated, is one that we tentatively approved in our last session, but you, of course, are open to change your mind before agreeing to that during this session, and that is that we ought to -- the bottom line is that we ought to know more before we recommend there's a change in payment under the Medicare+Choice.

The specific wording is in the second half of the page.

DR. ROWE: In the payment methods.

DR. WILENSKY: This is in terms of whether the payment method for Medicare+Choice should be changed from

systematic problems. In order to know that, you need to have more information and we plan to monitor and analyze the characteristics of the plans that are leaving and considering the participation benefits offered enrollment in general.

So with regard to this recommendation, we are indicating interest, concern, intent to monitor, but no specific recommendation to do anything different as of this time.

DR. ROWE: Just for my information, I don't track this as closely as many people, but we had some discussion because there was a lot of publicity about a flurry of plans leaving.

DR. WILENSKY: Right.

DR. ROWE: And then the Secretary said, this is the market and it will calm down and we haven't had much discussion about that the last couple of months. What has been -- what has happened? Have more plans left? Has it slowed down?

DR. WILENSKY: Well, more plans really haven't had an opportunity to leave yet.

DR. ROWE: There are certain windows in which they can leave?

DR. WILENSKY: Right. And I am personally not overwhelmed by the statement this is just the market working, but having said that, and I think there was no one that I am aware of or no organization that predicted you would have withdrawals.

DR. ROWE: If it was just the market, it would have been -- if Donna was right, it would have been predictable to some extent.

DR. WILENSKY: There were certainly no predictions by CBO or HCFA that this was going to happen, and the question of whether or not we should make a recommendation regarding changing of the payment structure is premature.

DR. ROWE: Just seems too soon.

DR. WILENSKY: We just need to have more time to monitor what is happening. I think there are --

DR. ROWE: When is the next window in which the plans could leave if they wish to?

DR. WILENSKY: The big issue will come up in May.

MS. NEWPORT: May 1 was the next scheduled ACR

filings. They would have to announce then.

DR. CURRERI: I think there's a danger too that they may not be correlated at all and payment methods and plans leaving may not be correlated whatsoever. That's what we need more information about, to see what's causing what.

DR. ROWE: Is there any rationale to suggest -- again, I'm just asking -- to waiting with this recommendation or even with this chapter until May, until we see what happens? Then we have a little more time and maybe we won't be premature.

DR. WILENSKY: No.

DR. ROWE: Or you think we need another year anyway?

DR. WILENSKY: I think we need to say something because this is our March 1st report, so the issue --

DR. ROWE: So we can't really just delay it.

DR. WILENSKY: No. The report with regard to payment will be issued in March, so I think the state -- we recognize that an event has occurred which was not anticipated. We just think it's premature to make a recommendation about payment change, but we are going to

monitor what goes on. And then really in somewhat following along this line, we're concerned about the inability to offer different plans within -- which goes on to the next recommendation -- within the same market area where there are different payment rates.

So it's basically to indicate that we're concerned. We think it's too early to say what you should do.

DR. CURRERI: The most important part of this recommendation is the second part, which states what we're going to do.

DR. WILENSKY: Yes, that we're going to monitor so that we will see whether there is something that we think needs to be done differently.

DR. NEWHOUSE: I think there's potentially some -- I support the recommendation, but on this exchange about the Secretary's comment, there's a middle ground. You don't have to go all the way to say, well, it's just the market working. Maybe it is, we don't know.

But there could also be something wrong with the expectation, I think, of zero withdrawal. I mean, the

notion that we would pay a rate that would keep every plan, however badly managed, in the Medicare system is clearly wrong. So it's really a question of rate withdrawal and who's withdrawing.

I mean, is it kind of good guys that were really well-managed, but they got a lot of sick people and the lack of risk adjustment creamed them, or was it just a sloppy plan that was doing everything and couldn't make it on a fixed rate.

DR. WILENSKY: Which we do know that.

DR. NEWHOUSE: We know that plans don't make it in the private market.

DR. WILENSKY: But we know that the withdrawals are from the big Medicare risk plans.

DR. NEWHOUSE: They're even selective within the big Medicare risk plans and some of it seems pretty clearly to be the service area thing related to that, which is a kind of separable kind of issue.

DR. WILENSKY: Well, let me make a suggestion and continue on. One of the things -- I don't know whether this makes it too complicated for what it brings, but to indicate

in this year several factors were going on, including the requirement of an earlier announcement.

Given the requirement of an earlier announcement and the inability to make any subsequent changes may have influenced the number of withdrawals, and therefore the need to monitor future withdrawals, because one of the things that happened this year, of course, is that rather than have a November reporting requirement, plans were required to file in May and not allowed to make any subsequent renegotiation, so that part of what we may see is more the difficulty, or at least the first round difficulty, of having to file so early.

DR. NEWHOUSE: By the way, I like the last chart that Sarah and Scott had, which seems to point to a problem with the service area definition and we probably ought to draw that out in here.

DR. WILENSKY: I'm sorry to interrupt.

DR. LEWERS: I agree with the recommendation and I'll be careful not to upset my fellow Commissioners today, but I think that the other element we need to look at if we can and then whether anybody has any information is though a

number pulled out, there were a number of plans trying to get in.

Do we know of any movement in that area and whether any have been selected in some of those areas? Because that, you know, I think it falls within this recommendation. We need to monitor it and whether we know that at this point.

While I've got the microphone and just to save time, I agree with the second recommendation as well, Gail, except that I think it's very important, those last few words, without compromising the objective of the Medicare+ program. I would not accept it if those words were not there. So I'll save being recognized again.

MR. MacBAIN: Just another comment on this issue of looking at the effects of payment methods, because with what's going to happen between now and next May, I think, is going to be a reflection of how people evaluate HCFA's announcement tomorrow at 4:00 o'clock.

If we've had plans withdrawing from counties based on all the things that the balanced budget has wrought so far, which on the financial front meant for most counties

a 2 percent increase, now we're looking at some absolute decreases, which I think is going to overwhelm what's happened with payment rates so far to try to evaluate on the basis of the Balanced Budget Act's effect on payment rates until people get a good look at what the risk adjusters are going to do. It just wouldn't be very meaningful.

So I think that because the payment structure is changing a lot even as we speak, it makes sense to say let's watch this for another year and just get a sense of how people react and what's going on.

One other thing, again just to save a little time, when we're done with these four recommendations, I'd like to cycle back just with a couple additional comments. I don't know whether we'll want to make recommendations on, but at least things I want to get off my chest.

DR. KEMPER: I agree with the recommendation. I have a smallish comment. It seems that this one isn't really an overarching comment and that the second recommendation, which I also agree with to save recognition, is overarching and that we really want to highlight.

This one, to me, is just another recommendation

that ought to fit back, I guess, sort of page 27 and following where we're talking about the withdrawals. But it's partly to make it less prominent in the chapter, but also just it does seem to be overarching.

DR. WILENSKY: I think that we are speaking to an issue which has been raised and while our statement -- our recommendation is basically to sit tight, it is nonetheless a response to a very topical issue. So I would recommend that we have it as the first statement, but obviously if there's concern about its placement and the majority of you would wish to move it, we can do that.

Again, I think the fact that it is as topical an issue as it is makes it prominent even if our statement is not a strong one.

DR. LEWERS: I'm assuming we're going to list recommendations as we've done before in a separate area, so if that's the case, it doesn't really make any difference where it is.

DR. KEMPER: And I don't feel strongly about it.

DR. LAVE: I had a question that really is not related to the recommendation, but is related to the

discussion beforehand and really sort of a withdrawal issue. That had to do -- and this is the question that I think I'd like the plans to answer if they feel comfortable and that is that the Medicare payment is supposed to cover only the Medicare-covered services. Yet most of the plans have, in fact, added additional services which they cover with no cost-sharing or co-payments. I mean, that's the way that it's worked out.

They've absorbed a large part of the employee cost-sharing and may have added additional benefits at the same cost. So it really isn't surprising, as the fee-for-service system is tightened under reimbursement, that it is very difficult for the plans, in fact, to offer these additional benefits, and the fact that we expect they can, in some ways, I think we may want to rethink that as the fee-for-service side gets tighter.

The question that I have is a philosophical one on the part of the plans and that is sort of, how comfortable are they without offering more benefits than the Medicare? I think that may help us sort of figure out what they might want to do than the Medicare plans offer -- than is part of

traditional Medicare.

Part of the issue had to be, if I understand it, was that they wanted to offer fewer benefits. They didn't want to offer the same benefits within the service areas if they got different payment rates.

DR. WILENSKY: Judy, let me just, as I understand factually, what the request was was for the plans that were withdrawing. There was a combination request, some plans requesting one and some other, in September that they be allowed to make some modification with regard to their May 5 filing, either in response to your description to offer fewer extra benefits at the zero premium or to have the same benefit package, but to have an increase in the premium.

It was that inability to negotiate after the May 1st filing that led to the withdrawal in 1998. Whether there will be further withdrawals for other reasons in 1999 is a different issue, but as I understand what was told to me about the rationale for withdrawing, it was the inability to make any adjustments either with regard to the benefits above Medicare or with regard to the zero or small premium that had been included.

DR. LAVE: So basically that says that if they were willing to change those things, they were willing to offer a leaner or a more expensive product.

DR. WILENSKY: Right. That's what I understand.

DR. ROWE: Should we explain that in the chapter? Are some of the people who are going to be reading this, would they find that informative in terms of this issue? This is, as you kind of pointed out, Gail, kind of a topical issue.

MS. THOMAS: It's alluded to, but we could get it more detailed.

DR. LAVE: It's very obliquely -- I mean, you really have to understand the issue.

DR. ROWE: If this is really a topical thing, we should maybe -- just the two paragraphs you just said might be helpful to include.

DR. WILENSKY: I think it's important that neither we nor the public or the relevant community draw too many conclusions off of what happened this year for the future.

Now, again, there may be all sorts of reasons why other things are going to happen in the future, but this

year, because of the advancement of the date and the inability to make any adjustment after May but before the year ended, produced changes that we found --

DR. ROWE: Well, that's what I'm saying we should say because a lot of the plans are maybe broadcasting a different reason.

DR. CURRERI: Are there really enough plans and enough data that we know that that's a real reason? I mean, people say I got out of this because I couldn't negotiate, but there may be another reason they're not talking about. I just don't know how well --

DR. WILENSKY: Well, we ought to be clear that it doesn't detract from the issue about monitoring, but we can probably do that. If, as part of our monitoring, we may or may not be able to assess the nature of the benefits offered or the premiums charged in some of the plan market withdrawal areas.

We could, at the very least, indicate that this is what the plans have indicated as the reason for the withdrawal in this year and we do know, at least at a factual level, that in the first place, they had to report

earlier than they normally have, and in the second place, that they attempted to renegotiate with HCFA in September. We do know that those two events are going to --

DR. CURRERI: Right. But another plausible reason is they negotiated with their providers to lower costs too and they didn't get anywhere with that. I mean, we don't know that. It may be that providers in certain cities were rigid in terms of renegotiating their contracts at decreased costs which the plans felt they had to have because of the early filing.

I can see a host of different things other than just the fact that they couldn't negotiate with HCFA, they could have said to a plan, we move out of this area, but we're not going to move out of that area.

DR. ROWE: Maybe a benign sentence such as, as has been the case of the residency reduction waiver program, HCFA's inability to be flexible under those --

[Laughter.]

DR. LAVE: Not confrontational.

MR. GUTERMAN: There's actually a third item on Gail's list that is alluded in the chapter that I think

needs to be brought out here and that's that not only did the date move up to May 1st from November, but also there were a large number of very important events that happened after May 1st that crystallized the plans' impression of how the program was going to work.

The mega-reg came out in June, which was fully six weeks after the plans had to submit their ACRs for the following year and it's not only the movement of the date, but also the lack of information about what the program was going to look like.

DR. WILENSKY: I think that this issue needs to be addressed to some extent. We will see it and if people are uncomfortable, we can modify it. I do want to encourage people to be mindful of the time. We need to make sure we get through these recommendations, but also that paragraph on page three that is not in bold print that references the phase-in and other issues with regard to risk adjustment.

DR. CURRERI: If we're going to vote on that recommendation, can we get a number in the blank there? It says, we recommend risk adjustment should be phased in by...

DR. WILENSKY: I have Janet here who wanted to

speak before we will.

MS. NEWPORT: I appreciate the Commission's recognition of the variety of reasons that plans had problems last year and I think you saw one plan and you saw one set of reasons. There may have been congruency amongst some plans.

I think that our experience was varied across the country and our decisions were varied across the country, but I think the primary driver, though, was what Stuart has said, is the regs came out after the filings, but the other part of this had to do also with the need to have at least two quarters worth of cross-data under your belt before you can really establish the right product pricing for next year.

That runs right up against the information campaign and that seems to be the loggerhead part of this. Other than that, I think that this recommendation is reasonably written enough, the first one, more study needed. I've gone down that road a couple of times and recognize the limitations this organization can bring to this as well.

So I think that I would just say that it's early

days yet. This year we'll have tomorrow's announcement. We have a March 1 announcement that will fill in more of the blanks, and I think between now and May, I think we'll have a fairly -- maybe not reasonable, but we'll have some indicators of what the market response will be.

MR. SHEA: Can I ask a question on this? Do we know if the May 1st date problem was a start-up year problem or is it going to be an annual problem?

DR. WILENSKY: I think it's some of both. What I heard was that May 1st allows, at most, first quarter experience and that having the first two quarters and perhaps coming in with a July submission or a late July submission would provide a lot better information to use for your 1999 bid.

Initially, what I was hearing during this discussion about whether HCFA would allow any late renegotiation was a willingness to consider something like a July submission date rather than the initial May date. I don't know where that discussion is.

MS. THOMAS: This year there would need to be a legislative change.

DR. WILENSKY: I understand that. So I don't know whether it is likely to change. What I had heard last year is that it was more than a start-up.

MR. SHEA: I'm sorry. This is a legislative date?

DR. WILENSKY: It would require a -- now it requires a legislative date.

MS. THOMAS: This year the date is in the statute.

DR. CURRERI: Could I ask the people from the plans, if you use the last quarter and the first quarter, the last quarter of the previous year and the first quarter, could you use that data to come up with the May 1st or does it have to be the first and second quarter of the calendar year?

MS. NEWPORT: All I'll convey to you is what's been represented to me by the operational staff within our company. When we talk about January 1 start dates and new payments rates that are based on an annual payment revenue flow, that they're saying the first two quarters are necessary to get under your belt.

There's a lot of things that happened last year, too, in terms of increased drug prices, which would affect

the co-pays that we would have had applied to optional supplemental benefits like drugs. So I'm just reflecting what I have been told. Maybe Alice can comment.

DR. KEMPER: And if you change the benefit package, that wouldn't have been affected?

MS. ROSENBLATT: Bill, I'm going to give you a general actuarial answer, not an answer specific to any plan, but just in general terms, it, I think, has to do with the reported reserve. It's very hard to set that reserve for the fourth quarter and the first quarter because fourth quarter is generally a low seasonality effect because of the holidays and the first quarter is generally an offsetting high effect.

If you're looking at just experience through the end of March, you really don't have a complete handle on your fourth quarter. You're still guessing at some of that, and you're just about totally guessing on your first quarter. So that's what makes it difficult.

DR. WILENSKY: Let me raise these first two recommendations, other than perhaps adding some discussion. It is to recommend no payment change, but monitoring first;

and the second, to continue with our recommendation that HCFA work with the organizations offering plans and have some flexibility without compromising the objectives of the Medicare+Choice program. These are both recommendations that we saw last time. Is there any modification or a change that people would like to see?

DR. LEWERS: No change in the recommendation, but where you're adding it, I think we should be as factual as possible and not deal with what we've heard.

DR. WILENSKY: And we don't need to put that in the recommendation. We can put that in text around that.

DR. LEWERS: But even in the text it needs to be factual.

MS. ROSENBLATT: I have no problem with the recommendations, but just one minor thing to be added to the second recommendation. It sounds to me like there are special circumstances this year as well as last year because of the March date versus the May date. The fact that the HCFA report is not coming out until March, I think, will again make May a problem and if we could just add that.

DR. NEWHOUSE: That sounds like something for the

text.

MS. ROSENBLATT: Yes, that's what I'm saying.

DR. WILENSKY: Go ahead, Judy.

DR. LAVE: As I've listened to the discussion, it seems to me that the plans at least have been saying that the current dates -- I mean, HCFA can only be flexible within the confines of the law and that there are significant problems with the dates embedded in the law.

Do we want to say anything specifically about that issue or do we feel that we know enough? I mean, it strikes me that maybe the Congressional dates are wrong and that we may want to say that they ought to be changed.

DR. WILENSKY: That is what it sounds like. Is there an interest in proposing that the date be moved to -- I don't know whether July or to a later time that will allow for second quarter?

DR. NEWHOUSE: Well, I thought we got to these dates because HCFA said they couldn't do the notifications to the beneficiaries and all of that.

DR. WILENSKY: That's all very nice, but to say that you have to have a May 1 report because you have to

notify --

DR. NEWHOUSE: No. I'm comfortable with pointing out the downside of these dates.

DR. WILENSKY: I guess the other response --

DR. NEWHOUSE: Judy, were you thinking of a recommendation to change the statute?

DR. LAVE: I was thinking of a recommendation. I mean, we've basically been hearing here that the current dates are almost unfeasible and don't work and that we perhaps ought to raise the ante and say that assuming that this is the case, which seems to be the case, that you need to have two quarters in order to come up with a reasonable bid. That it makes sense for us to suggest a congressional change.

DR. NEWHOUSE: Well, before we go to the change, we need to have some sense that, in fact, HCFA could -- if given more resources, for example, it could implement this.

DR. LAVE: Well, but that's the issue. The question is if HCFA were given more resources, could it, in fact, make the beneficiaries --

DR. ROWE: Or reallocate its resources from --

DR. LAVE: It doesn't have very many resources to allocate.

DR. ROWE: But if the implication -- if I understand this, which is not likely -- but the implication of our statement that more time will answer the question, is that, in fact, if we have more time, we're going to have two year's experience or three year's experience, whatever. And it sounds like we're at risk at having one year's experience three times and it's going to repeat this over and over again because we have a structural defect so that actually more time may not answer the question. I mean, that's what I'm hearing at least.

DR. NEWHOUSE: Well, its idiosyncratic feature needs time like the risk adjustment.

MR. SHEA: I wanted to underscore Joe's point about looking at the effects of this. I think we're clearly of a mind to say this date is the problem, it ought to be changed. But I think the default position -- we only said that so therefore, HCFA may not be able to do this and well, if they can't do it, they can't do it.

And I already think there's a little bit too much

of that in some of the later sections of this, that well, we want a quality system, but it's too complicated. We want a quality system, but plans don't want to participate in it. We want information, but there's not enough. So we can't do all that stuff. That was just a bad idea.

I think that's absolutely a wrong approach. I think we need to be strong in here about the principles of providing information so consumers make decisions is absolutely right and we should work these things out, and it may take more resources.

Now, that may not be a message some people want to hear, but I don't want to just kind of go down the road of well, all this other stuff that's not going to work, we'll do without it.

MS. ROSENBLATT: I just want to add a couple of thoughts to this because I'm not sure that we want to make that kind of recommendation. I just want to hit on some timing issue.

DR. NEWHOUSE: Which kind of recommendation?

MS. ROSENBLATT: About change the law to be a later date. I just want to call to your attention a couple

of things. The comment you made about the IBNR first of all would not apply to plans that have a percent of premium type arrangement with the providers because there would be much less IBNR concern in that type of arrangement. So it would only apply to benefits where the providers aren't on the risk.

The second thing is just in terms of thinking through the timeline, if we're saying that we really want for the plans to have second quarter data, then they're not going to have that until some time in late July, mid to late July. Then they've got to start the ACR filings.

So it's not like a July 1st date would work. You're really pushing it out probably until August 1st or maybe even later. I would rely on Janet for --

DR. CURRERI: Probably back to November.

MS. NEWPORT: It's feasible probably late August or 1st of September.

DR. WILENSKY: But it would strike me that however far you move it out, you are providing additional data.

Now, the issue that Gerry raised, I happen to be very much in agreement with, which is we had to be careful

not to fall into the trap just because someone says they can't do it or they won't do it or if you do it, they won't play, that we not make a recommendation that we think is appropriate.

We may not wish to make a recommendation to move the date. We can get a sense about that, but I would not --

MR. SHEA: I think it's obvious that they need to legislate a fifth quarter. The Balanced Budget Act is right. All we need are five quarters to make it work and then we'll be okay.

[Laughter.]

DR. WILENSKY: I think we ought not to accept a statement if, in fact, it is a HCFA statement, that the date is May 1st because that's the amount of time they need in order to get the information out to beneficiaries. I don't know that we ought to accept a six-month requirement as written in stone.

We can either keep it as it is, suggest that it be made later to accommodate more information, be specific July 1st or not be specific if we wish, but I support the notion that because the statement was made, this is how much

time we need in order to get the information out to beneficiaries, that should not be our determining factor. Peter, Ted.

DR. KEMPER: It seems to me that there are two timelines going on here and we've heard a lot about one, but we haven't heard anything about the other. There may also be mixed strategies where you file a plan, but you're allowed to have an amendment in September if things turn out differently.

So it seems to me that if we make a recommendation on this, it shouldn't be change the date to so-and-so, but a more general recommendation that says, HCFA ought to explore ways of delaying that date allowing plans more flexibility that will also allow them to get out the beneficiary information.

Putting a new date in law doesn't seem to me necessarily that that's going to solve the problem.

DR. CURRERI: Haven't we already done that in the second recommendation?

DR. KEMPER: In a general way, I guess that's right.

DR. ROWE: In a wimpy way.

DR. LEWERS: I would not recommend recommending to Congress that they change the date. I think we've said in both of our recommendations that we seem to have agreed to that it's too early and that we need to work and do that. I think we need to leave the first two recommendations where they are currently. We'll have more information at a later date and I think that's where we need to stay.

DR. WILENSKY: Just understand that under current law, it cannot be made later than May 1st. There is no flexibility no matter what we suggest. Janet?

MS. NEWPORT: I would obviously like to see a recommendation that consideration be given to delaying or postponing the filing date. I think it's a real important driver in terms of not only the benefit packages and what is available for beneficiaries, but the amount of choice that will be out there.

I think we need to link up the impact on the beneficiaries that could be more positive with a longer time to file. Then also, I agree with the notion that we shouldn't lose sight of the fact that blanket advocacy for

delay is something that we would support. I think the frustration from the plans' side is so much is happening at the same time.

Every aspect of the regulatory schematic is being changed, sometimes more subtly, sometimes more not subtly at all, and that the total impact of this is somewhat overwhelming. I mean, there's not a week goes by that we don't receive a new operational policy letter with one or two days to comment on any changes.

That's literal. I think that that's part of the issue here, is that things could be queued up by priority and what are the critical mass issues that should be addressed, and then what are those that can be taken up later and implemented in a more judicious and less sort of firefighting manner. I would be happy with that distinction being made.

DR. ROWE: But we had heard at one prior meeting, at one session or another that there might be some legislation which would be kind of a technical fix of some of the oddities or whatever of the BBA, any bill that comprehensive is often followed, I gather, by that kind of

bill.

Well, if that's the case and if this kind of a change could -- if the timing is such that if we recommended a date change now, it could be included in that technical fix bill and this is more than a hypothetical that wouldn't require legislation. It might be that we could have a chance by mentioning it now and getting it in the March report that we could get it in that bill if that's actually going to happen, and it would be very propitious timing.

DR. WILENSKY: The notion, if we think having a delay, specified or not, in the filing date is appropriate, we should say so because there probably will be a technical bill. If we don't wish to be that specific, then we ought not to say so.

But I think that we need to recognize that the recommendation we have now, that HCFA should be flexible, does not allow for this kind of flexibility, and if we think there's a problem with the filing date and it should be moved later, we either can say that or say how much or pass on it, but we are --

DR. ROWE: Could we say that we would recommend

that the legislation be changed to permit HCFA to have greater flexibility with respect to the date without putting a specific date in?

DR. NEWHOUSE: I suppose if I were the plans I would say, gee, HCFA will just stick with their existing date. Why should they move? Speaking for myself, I'm certainly comfortable with saying that there's -- pointing out the downside of this date and saying something like exploring the possibility of moving it later.

DR. CURRERI: I think the only thing I'm not very comfortable -- I perfectly agree with Joe, but I guess I'm not very comfortable myself in mentioning a specific date because --

DR. NEWHOUSE: We just don't know enough.

DR. CURRERI: Yes, I just don't know what the mechanics are for Janet's plan. September 1st might be fine, but other plans, it might be later than that.

DR. WILENSKY: One possibility would just be to say that having moved from November back to May has appeared to cause a lot of problems. Finding a way to move the date back or, I guess, forward, would be -- to make a

recommendation to move it forward to an extent that allows information still to be --

DR. NEWHOUSE: Create substantially more uncertainty about what future costs will be.

DR. CURRERI: Would it be appropriate to ask the staff to draft a written plan and we could look at it tomorrow? I think this is something we should see in writing.

DR. WILENSKY: And we can look at that for tomorrow.

DR. NEWHOUSE: We've still got the phase-in.

DR. WILENSKY: The more serious is in the third recommendation, which is what is now written in regular print about our recommendation regarding the phasing in of a risk adjustment.

DR. NEWHOUSE: I suggest instead of trying to pick a date by when it should be fully phased in, that we, although we'll know tomorrow so we may want to revisit this, we would say that we recommend that risk adjustment go forward in January of 2000.

DR. WILENSKY: I think we should have a phase-in.

If we don't want to specify the date, whether it's a two-year or three-year phase-in, but I think we ought to have a two-part; that it should go forward in January and it should be phased in.

DR. NEWHOUSE: Fine. I just didn't want -- the text that I was looking at left a blank for a date.

DR. ROSS: I think they're referring to method.

DR. LAVE: I think it should be a three-year phase-in.

DR. ROWE: But that's the end of the phase.

DR. NEWHOUSE: Oh, method not date. Right. I misunderstood, Murray. I thought this was supposed to be by -- it would be fully phased in by some date and we were supposed to fill in the date. Well, then I also think it should be phased in by a blend and if we could say and a corridor if possible, if we want to do that, but I would prefer a straight blend, then we'd have to find out if the two are possible.

DR. LAVE: I have a question about the phase-in. It strikes me that we want -- I would suggest that this phase-in that we have now should be a phase-in consistent

with the risk adjustment that is being used. So if this risk adjustment method we think is going to be in place for three years, then we might want to have a three-year phase-in.

It strikes me that if the risk adjustment changes dramatically, we may be back all over again with a different phase-in because winners and losers are going to change with the new one.

DR. NEWHOUSE: That's why I started with just go forward. I mean, start out down the road.

DR. LAVE: But we need to figure out whether it's going to be a 70-30 phase-in the first year.

DR. NEWHOUSE: Why do we -- well, HCFA is going to make a proposal, I think, that we could then react to on the degree of phase-in.

DR. LAVE: All right.

DR. WILENSKY: So right now there's -- I mean, that is our understanding, but if we don't have a common phase-in, where we are really is back to current legislation, which is not only that it starts in 2000, but that it happen fully immediately and we don't mean that.

You're at the other end.

DR. LAVE: I think we should say a phase-in and then HCFA will tell us what it plans to do and we can decide next year whether we think they're off the wall.

DR. NEWHOUSE: No, I think we can decide before then.

DR. WILENSKY: Before our report is due.

DR. CURRERI: I think we also should recommend, and I agree with Joe, that a blend be used only because I don't see how plans are going to deal with the uncertainties of the corridor added on to that. They're just not going to know until the end of the year where they fall in that corridor.

DR. WILENSKY: Any further discussion about whether to recommend a phase-in with a blend only as opposed to a phase-in that includes both a blend and a corridor?

DR. NEWHOUSE: Everybody likes blend.

DR. WILENSKY: I'm going to assume the absence of discussion indicates both a phase-in and a blend.

DR. CURRERI: But I think we also need to see this written out tomorrow because I agree that the recommendation

for both the starting date and the length of phase-in or some discussion about what the length of phase-in should be, and presumably we'd like more information.

DR. NEWHOUSE: Well, my problem with specifying the length is I'd like my comment about generating some evidence on what the incentive effects will be. As I say, I don't think they're going to be very much, but if they were, then I would want a longer phase-in or even a stop in the phase-in. It's too soon at this point.

DR. CURRERI: But if you're going to have a blend, you're going to have to start out with some --

DR. LAVE: With a blend.

DR. NEWHOUSE: Yes. Well, you clearly have to specify year one, potentially year one and two.

DR. WILENSKY: Julian?

MR. PETTENGILL: Just to be sure that we have this clear, you want it to start on January 1 of 2000?

DR. WILENSKY: Right.

MR. PETTENGILL: And you want it to start with a blend.

DR. WILENSKY: Right.

MR. PETTENGILL: We will leave a blank that enables you in the next -- once we know more about the HCFA proposal, to make a specific comment about what the blend factors should be.

DR. NEWHOUSE: Okay. Both that and potentially the how long, although --

DR. WILENSKY: One may tell you the other.

MR. PETTENGILL: We will leave a blank so you can specify the transition sequence of blends.

DR. WILENSKY: All right. I thought I just had asked if anyone is uncomfortable with phase-in and blend as a recommendation, speak up, and I'm now hearing a voice.

MS. ROSENBLATT: I thought, Joe, that you were saying you ideally want both blend and corridor, but we don't know that they can do that.

DR. NEWHOUSE: No, I actually personally would prefer not a corridor, but if the corridor were loose enough, I could live with it. But as I hear the rumors, HCFA can't do both, so it's choose one, but we could verify that. And given the hour, we maybe should hold on further discussions. We're going to want public comment. We're

supposed to take up PPS updates at 1:00 o'clock.

DR. WILENSKY: We have one more issue also with regard to the flexible benefits within the market area. That's on page 18.

Now, this is again something that we had tentatively agreed to last time. I just want to allow people to make sure they're still comfortable, that the Medicare+Choice organizations should continue to have the flexibility to tailor their benefit packages within the areas as long as the Medicare payment is bearing.

DR. NEWHOUSE: Do we want to say more pointedly that if you're going to pay by county, you want to have the service area by county?

DR. WILENSKY: I think this basically allows that.

DR. NEWHOUSE: It allows it. I mean, the issue is whether you want to be more direct.

MS. NEWPORT: It depends on how you define service area, Joe. You can have a delivery system that is bigger than a county.

DR. NEWHOUSE: Oh, yes. I'm sorry. I meant for the purposes of the supplementary benefit package.

MS. NEWPORT: Maybe we can talk about that further. I would caution.

DR. WILENSKY: If people are comfortable, I think the wording accomplishes what we needed to have accomplished, so if people are comfortable, let's leave this on here.

DR. NEWHOUSE: That's fine.

DR. WILENSKY: Anything further?

DR. KEMPER: Yes. We had in the past had a recommendation about moving as quickly as possible to encounter data. I think we still believe that. Is that something that others would want to reiterate? It seems to me that I would find it -- I think that's very important and I would want to just formally reiterate that same recommendation that we had made in the past, even though it's in the works and so on.

DR. CURRERI: I have just one editorial comment and that's, at least in my copy, pages 41 and 42 are exactly the same as 39 and 40.

MS. THOMAS: I apologize for that. That was a mistake.

DR. CURRERI: I just wanted to make sure you caught that.

DR. WILENSKY: To the extent that we can see the attempts to put a recommendation in writing that reflects what we are discussing here today by tomorrow, that would allow comment.

MS. THOMAS: Three recommendations; is that right? Two on risk adjustment and one on the timing of the ACR submissions?

DR. WILENSKY: I think there are actually four. There are two here, the phase-in is the third, and the service area is the fourth.

MS. THOMAS: I'm sorry, three new ones.

DR. WILENSKY: Oh, three new ones.

DR. KEMPER: What about the reiterating --

DR. WILENSKY: Right. And the reiteration of the full encounter. Okay.

MS. THOMAS: So the specifics around the risk adjustment phase-in, the reiteration of the risk adjustment, collecting encounter data from all sites of service, and this new one on the ACR submission date?

DR. WILENSKY: Right. So there will be five recommendations all together.

MS. THOMAS: Total.

DR. WILENSKY: Right. Three new ones.

MR. SHEA: Just getting back to the point I made before, I would suggest that the sections on the beneficiary data and the quality do a good job at raising the complexity and the difficulty and the expense of doing this, and a better job than those sections do at saying how important those are and how, from the beneficiaries' point of view, how central those are of the whole enterprise here, and I just would suggest we could strengthen that up a little bit and it would be more balanced.

DR. WILENSKY: We are running late, but let me open this up for public comment. This is clearly an important area. Don, welcome back.

MR. YOUNG: Thank you. Don Young from American Association of Health Plans and it is a different feeling back on this end of the room at the microphone.

You've had a wide-ranging discussion today on a lot of issues and they certainly bear a lot of discussion.

I want to comment just on a couple.

One, you've come back repeatedly to the instability in the Medicare+Choice market. It is our feeling in talking to people that that instability is certainly going to continue next year, but it's likely to get even worse.

The central issue I want to talk about is the risk adjuster, and again, I will do it very quickly. Three points. One, as you discussed, it has terrible incentives, but even worse than that, it has terrible penalties. By using a hospital admission risk adjuster, plans that have really done an effort to keep hospital stays where they should be will be penalized by this system.

HCFA has considered lopping off short stays. We're concerned even there that the short stays, lopping that off, will make it even worse because the number of discretionary admissions in fee-for-service is so much greater than the discretionary admissions in health plans and managed care +Choice organizations.

Second, the data that they're using is severely flawed. Despite valiant efforts, it's in the plans'

interest to get 100 percent of their hospital admission data in, many of them haven't been able to do it for a number of complex reasons, and we could talk to the staff about it. And those that are being submitted have been found to have substantial errors associated with it.

The third is the issue of budget neutrality. Those of you that are BBA historians, this started with the president's budget. The president submitted a proposal for a risk adjuster and the president proposed a fall-back of 5 percent cut if the CBO would not score the risk adjuster without that.

The minus 8, minus 5, minus 5, minus 5 was put in place as a budget-saving initiative by the Congress to deal with the equal amount of savings that were in the president's risk adjustor. Unfortunately, none of that is in committee reports. It was certainly in the minds of the folks that were around. But one of the reasons you have to ask of why the .8, .5, .5 came about was that. That relates to my final point.

By 2002, the end of 2002, Medicare+ risk contract payments will be 89 percent of fee-for-service payments.

That comes in measure from the reductions that are already taken. If HCFA proceeds to introduce a risk adjuster and that risk adjuster is flawed and redistributes payments or lowers payments, and particularly does so inappropriately and reduces that level even more, the market instability and the impact on beneficiaries will continue. Thank you.

DR. WILENSKY: Thank you, Don. Yes, sir.

MR. SHIFFLIN: I'm Alfred Shifflin. I represent the Consumer Coalition for Quality Health Care and the Center for Medicare Advocacy in Connecticut. My concern and comment goes to the recommendation that's under discussion with respect to organizations being allowed to vary benefits within the service areas.

I think that's a very serious set of concerns and I would like for this committee to consider that very carefully before moving in that direction. I think already we're in the situation where Medicare+Choice has substantially destabilized the Medicare benefit as it existed over time.

I think this is the kind of thing that moves us further along that line where we don't have the

predictability of services and scope of benefits and that kind of things, that there's that kind of variation. So I would like to see that really explored carefully before a recommendation is brought forth. Thank you.

DR. WILENSKY: Thank you. Any additional comments?

We are going to break for lunch late. Could I ask the commissioners to reconvene no later than 1:15? That will be an abbreviated lunch period, but we have a very full afternoon.

[Whereupon, at 12:41 p.m., the meeting was recessed, to reconvene at 1:15 p.m., this same day.]

AFTERNOON SESSION [1:28 p.m.]

DR. WILENSKY: The first session for the afternoon is on PPS operating update recommendations. Now that we had such an easy time getting through the morning, we'll go to the less controversial areas. Jack, Andy, Nancy, and Tim, please begin.

MR. ASHBY: We somehow managed to squeeze in up here. We're doing staff togetherness today. Shall we forge ahead?

DR. WILENSKY: Please.

MR. ASHBY: Okay. As we talked about in our last meeting, we have, for the last decade, been using a framework with eight components to develop our recommendation for the annual update in PPS payment rates.

At our last meeting, we reviewed each of those eight components and today our goal is to finalize the recommendations. We're going to do this first for the operating update, and in a separate session, for the capital payment update.

The discussion of these updates is in the third chapter of the March report, which we are going to call

prospective payments for hospital inpatient services, and I would point out that that chapter also includes a section on disproportionate share payments which will be the next agenda item down the line.

Before I begin on the actual update process, I'd like to remind everyone that the PPS operating updates for future years are already set in law, as we see in this overhead. For fiscal year 2000, the update will be market basket minus 1.8, which with the latest forecast of the market basket, translates into an update of .7 percent.

Then for the next couple of years, we're at a somewhat more liberal level of market basket minus 1.1, and then in 2003 and beyond, it's set at a considerably more liberal level of market basket even. Those out-year rates, as I think was said at our last meeting, are perhaps ripe for change.

In fact, the administration indicated this week, indicated in the form of articles in the Washington Post and New York Times, that it does intend to seek a reduction in PPS payments as part of its FY 2000 budget proposal. The suggestion was for a 1 to 2 percent cutback over the next

five years, and although no mechanism for achieving those savings were specified, obviously an update is there as a candidate.

The next overhead then shows the levels or ranges that we have proposed for each component of the framework. We have three presentations planned for each of these components in the order that you see them there, focusing on how we arrived at these numbers.

If you believe that any changes in the component values are necessary, we can open up discussion at each point along the way after the end of each presentation and we'll record them on the overhead. Then when we have arrived at the final set of component values here, we can come back and craft a specific recommendation statement.

So unless there are any questions up front, I'll turn it over to Andy to discuss the first three components here.

MR. COSGROVE: Thanks, Jack. I just wanted to say, when I got the call that we needed a lot of work done on the market basket, I thought maybe I'd be coaching hoops in Milwaukee at a Catholic university, but it turned out to

be this.

Anyway, as you can see up on the board, the fiscal year 2000 market basket forecast is 2.5 percent. That's a pretty nice, normal number compared to what we've been seeing in the last few years. It's following a pretty close trend.

Going down the adjustment for the difference between the HCFA and the MedPAC market baskets, that represents probably as you know, just a slight difference in the make-up of what we consider a good market basket and the way HCFA does theirs.

We just weighed the wages in the hospital industry in the labor component a little more than HCFA does, I guess, because hospital wages are lagging behind a little bit compared to the general economy. There's just a minus .2 percent adjustment there.

If I can take you all the way back several years to January of 1997 -- yes, it was a simpler time -- the recommendation came out to be zero and that was the update in law for '98. So because the update was not based on the market basket, it was just called zero, we're saying that

there doesn't need to be a correction for market basket forecast errors.

I guess we can move on to the next part of the update framework and Nancy.

MS. RAY: Thank you. The Commission's hospital payment update framework includes an allowance for scientific and technological advances, and this is referred to as the S&TA. The S&TA accounts for emerging uses of technologies that are quality enhancing, but cost increasing.

The S&TA allowance is a future-oriented policy statement intended to estimate changes in resource use due to the adoption of new technologies in the upcoming fiscal year compared to the previous fiscal year. The work that we have done this year is a qualitative analysis that's based on work previously undertaken by ProPAC.

Specifically, the criteria set out by ProPAC to identify new technologies include that the technology is FDA approved, at least 5 percent of Medicare beneficiaries will receive the technologies and no more than 75 percent, and that the application of the technology will result in

substantially higher treatment costs but is quality-enhancing.

For this year's analysis, we reviewed the scientific literature, newsletters, periodicals, trade journals, and a lot of Internet Web sites to identify any new technological advancements anticipated for the upcoming fiscal year.

We specifically, as a starting point, we started with the four broad categories that were set forth in the fiscal year 1999 S&TA analysis, which are information systems, cardiovascular drugs and devices, biotechnology, and radiology in nuclear medicine.

Our review suggests that there's no change in the level of adoption of new technologies in the upcoming fiscal year compared to fiscal year 1999. Our review also suggests that advances are slowing somewhat in areas that have made important contributions to the S&TA allowance in the past such as the cardiovascular area.

However, we do anticipate substantial advances in hospital information systems in general, and addressing year 2000 computer problems in particular, and we believe

that the year 2K problems will significantly affect hospital costs in both their clinical as well as administrative operations within hospitals.

Therefore, staff is suggesting that the Commission consider increasing the S&TA allowance by .2 percent to account for these year 2000 improvements. We recommend an S&TA adjustment of ranging between .2 percent to .7 percent, and just to remind the Commission, last year's fiscal year 1999's update was zero to .5 percent.

An issue that I just want to quickly bring up is that by the Y2K fixes that we are explicitly accounting for by this .2 percent increase don't specifically fit the criteria that I just mentioned that ProPAC has set up in that it is not a new technological advancement; rather, it's a fix of an existing problem.

However, staff consider that the improvements to the systems and devices are significant enough and should be included under the rubric of the S&TA. So by increasing the S&TA by .2 percent for these Y2K problems, we will reconsider its inclusion in subsequent S&TA analyses.

DR. WILENSKY: Do you want a clarification?

MS. ROSENBLATT: A clarification on the year 2K. It seems to me, all the reading I've done and what my company is doing, you need to be compliant by 1/1/2000. So if we're trying to project year 2000 expenses, it would seem to me that most of the expense would need to be incurred by the end of '99 and that the only thing you'd have in the year 2000 is maybe some stuff that you didn't quite get right, but it should be a big drop from '99.

MS. RAY: AHA actually did a survey of many of its member facilities and there was still a fair percentage that were still going to be fixing -- addressing problems during the year 2000.

DR. ROWE: I can maybe address that, Alice. Gail, is that all right?

DR. WILENSKY: Sure, please.

DR. ROWE: We can get later, I guess, into specific numbers if you want to. I think that what we see -- there are many people who think that a hospital, particularly an operating room or an intensive care unit, will be a more dangerous place to be at the Y2K moment than in an airplane or any other place. Okay?

I don't really know where I want to be, but I know where I will be because I'll be at work in the hospital, obviously, at that moment, but I can tell you, I don't ever want to be at that moment in a hospital that only spent 0.2 percent of its operating budget preparing for this problem.

I can give you some data on what it's actually costing. But the issue is, of the thousands of things that have to be done, there are a bunch that are absolutely essential for patient care and they're getting done this year, and then there are a whole bunch that everybody is saying, we'll have to do that later.

MS. ROSENBLATT: Then I'm scared to death that insurance companies won't be able to pay hospitals if they're not focusing on billing systems.

DR. ROWE: Well, I understand that, Alice, and as an actuary you might prioritize that payment over actual life in that situation.

[Laughter.]

DR. ROWE: I don't think you want to go there, Alice.

MR. SHEA: It all depends on what your definition

of patient care is.

DR. ROWE: The other thing about the -- the other expense here -- so I think that there are these, like Microsoft has done a nice job of sort of categorizing these different things. It will injure people as an essential for survival of companies and the last is like convenient, you know, and we have that same hierarchy, so there's a big tail for the first two-thirds of the year 2000.

The second is the liability issue. Hospitals are very concerned that whatever happens at the Y2K moment that's adverse, they're going to get sued by a whole variety of people and there are a tremendous number of legal and documentation and other kinds of paradigms being built in and they continue in year 2002. So that's just an explanation of what I think might be. As I look at my prices for '99 and 2000, I have a Y2K line for both those years.

DR. WILENSKY: Let me make a proposal. Any clarification issues, let us do as you wish them, but in terms of the recommendations, why don't we go through the entire presentation and then we'll come back and go through

each recommendation, if that is all right with the commissioners.

MR. MacBAIN: The Y2K costs show up twice, both in operating costs and in capital. Can you help us split those out as to what is likely to show up in operating costs, both functionally and also what we're really talking about here and what we're going to be talking about later in terms of capital costs?

MR. GREENE: One way of putting it is we apply the same S&TA factor in the capital update. We've not tried to split it out between operating and capital.

MR. MacBAIN: Because there is a big difference.

DR. ROWE: Can I have another clarification?

DR. WILENSKY: Yes.

DR. ROWE: If, to whatever extent Alice is right, that there certainly are very large expenditures mainly in '99 and not 2000, which is what we're talking about, for hospitals in this Y2K effect, could you remind me what we included as the update for the Y2K expense in '99 last year when we did that?

MR. ASHBY: We did not make specific provision for

it last year, so that essentially means it was zero.

MR. COSGROVE: It was mentioned as an issue, but it wasn't --

MR. ASHBY: It was not provided for quantitatively.

MR. GUTERMAN: It was embedded in the S&TA -- essentially, it was embedded in the S&TA factor for last year because it was mentioned and again, it was a qualitative analysis we did to see whether the trend was up or down. So that was part of the range.

DR. MYERS: On the Y2K issue, I'm sure it doesn't happen at Mount Sinai, but a number of projects that have not otherwise been fundable are now falling under the Y2K label. So we need to be careful about what you call Y2K.

You also need to understand that a number of projects that aren't designed just to get us through the year 2000, but are designed to take us from wherever we are to a much higher technologic state, that it goes well beyond the immediate issues required in order to pass through that point in time.

DR. WILENSKY: Do you want to proceed?

MR. ASHBY: All right. We can now turn to the through-put and the site of care substitution adjustments. I'd like to begin by taking a moment to review what we decided in these areas at our last meeting.

First we decided to change the name of the productivity adjustment to the adjustment for change in through-puts. This reflects the fact that the very concept of productivity requires measuring inputs used producing a constant output, when in fact we do not have the capability to hold quality or really any other aspect of the hospital product a constant while we are doing our measurement of the input/output relationship.

Then we also decided to narrow the scope of the product change adjustment. This is addressing overlap between productivity and product change that have been apparent. We decided to narrow the scope so that it covers only the dollar-per-dollar shift of costs from acute stays to other Medicare services, along with that, to rename it the site of care substitution adjustment to more accurately describe what it's intended to do.

As we talked about last time, product changes can

indeed produce system-wide cost savings and to the extent that that's the case, it should contribute to the industry's target for through-put or productivity change. But to the extent that the costs have simply shifted from one provider to another, there are no savings and therefore it cannot be a through-put improvement.

The site of care substitution adjustment attempts to adjust for this shift. As I think Joe suggested, it essentially corrects for it -- that's the concept -- so that Medicare gets what it is paying for in each separate setting.

In attempting to determine an appropriate level for the through-put adjustment, we have to remember that it is a target for the improvement that we believe the industry should be able to achieve in fiscal year 2000. So how do we decide what's achievable?

Well, first we decided at the last meeting that the productivity gains in the general economy does not necessarily represent an appropriate standard for the hospital industry. So we looked to the recent performance of the hospital industry itself, as represented by these

results from our analytical model.

In the first line, we see that the through-put gains were 3/10ths percent per year. That's the right most term and negative here connotes a through-put or productivity improvement. Then as we discussed extensively, we had a net product change of minus 2.4 percent a year, but that we thought that a specific amount of that was actually through-put improvement and we don't have the capability to nail that down quantitatively.

At any rate, our model only goes through 1996, but we can make some reasonable estimates of the results for 1997 and '98 because some of the key variables are available to us. That's the cost-per-case, length of stay, and case mix data, all have more recent observations available to us.

Based on that, we can see clearly that 1997 and '98 were different years. The aggregate performance of the industry, that's the minus 3.0, was better than ever and literally better than ever recorded in these data series. The length of stay decline was much smaller; therefore, the net product change we estimate at the quite small minus .5

percent.

That means that the through-put or the productivity improvement had to have been considerably larger. We estimate minus 2.5 percent. And, of course, that might even be marginally higher than that if part of that small product change is really a through-put gain.

So how to set the adjustment? If we believe that hospitals can continue to perform at the level that they have performed in '97 and '98, that would imply a through-put adjustment of minus 2.5 percent. But as you can see, we have suggested a range of minus 2.0 to minus 1.0.

Besides the obvious notion that our ability to measure these things is less than perfect, the important factor here really is that we really don't think that this rate of change is sustainable and we have to have a somewhat more modest figure.

So just to put this in perspective, this is a large adjustment by the standards of what we have adjusted in the past, but it is still smaller than implied by what has actually been achieved over the last couple of years. Clarification?

MR. JOHNSON: May I have clarification? How does length of stay affect this calculation?

MR. ASHBY: Basically what we are trying to do is to calculate the impact on costs net of what results from length of stay being reduced. So in a sense, it doesn't affect it. This is the net of length of stay change. But as we pointed out, there was very little length of stay reduction in '97 and '98 anyway, and so in that sense, it has little effect.

As for attempting to quantify the site of care substitution effect, as a reminder first of all, this is not a policy target for change expected in FY 2000, nor would it be correct to call it a retroactive adjustment. What it is is an adjustment to the base rates for fiscal year 2000 to account for site of care substitution that has occurred in the past.

Our accounting begins in 1992. That's the first year that the decline in length of stay was large enough to produce a net decline in hospital product. Over the 10 years previous to that, length of stay went up slightly, went down slightly, but there was no net change in hospital

product. That began in '92 and ran through '98 in our calculations.

Our estimate of the cumulative product change over that period net of what we've already adjusted for in the last two years is the 9 percentage points that you see here. But given our more narrow scope of the site of care substitution effect, we definitely cannot adjust for the full 9 percent and the question becomes what portion of it is site of care substitution.

We don't have the ability to determine that proportion quantitatively. As I said last time, there is ample evidence of large scale substitution, but that evidence is all indirect in nature. So this judgment, this decision is really rather judgmental.

We thought that an appropriate estimate would be minus 6 percent to minus 3 percent. That's half with a range around it, and then the final decision becomes how much of that to adjust for this year, and we suggested an adjustment of minus 2.0 to minus 1.0, which is one-third of the total, implying that the remaining two-thirds would be carried forward for application in future years. This is

really a phase-in of this adjustment.

DR. ROWE: Can I have a couple of clarifications about the site of service substitution in terms of how you're looking at it, Jack? The example that you give --

MR. ASHBY: In the text?

DR. ROWE: -- in the text says, if a skilled nursing day costs $300 and substituted for an acute day costing $900, the system-wide savings are $600.

Most hospitals have sort of overhead costs or fixed costs and variable costs, and if a patient isn't there who would otherwise be there, I'm not an economist, but you save on the meals and you save maybe on some of the drugs, but I think most economists -- and there are a lot of economists here so we should ask them -- would agree that there probably are some fixed costs that are still there. So the system-wide savings is not the total thing, so I wonder if you could help me with that.

MR. ASHBY: I think the problem there is perhaps the phrase system-wide savings. In this particular context, we have to look at it as Medicare's system-wide savings to the Medicare program as measured what is paid for these

relative services. They do not very accurately capture these marginal effects that you point out and that are very real.

DR. ROWE: But if from Medicare's point of view, if you don't recognize those costs in some way, then as you take more and more cases out, there's the incremental cost of the cases that remain must go up because you have -- maybe Professor Newhouse can help me. He's an economist.

DR. NEWHOUSE: Social costs ultimately have to be paid.

DR. ROWE: That's what I thought. So maybe the economists can help me with that. The other question I have had to do more with how do you relate this to the transfer -- I mean, I thought we fixed this problem in the BBA with the transfer agreement and the way hospitals get paid for transfer of patients from acute care to long-term care so we're not getting paid twice and stuff. That was sort of done for the ten most common DRGs, et cetera, et cetera, and so I didn't see anything about that in the text. Are we fixing this again?

MR. ASHBY: Basically that is a forward prospect.

It does indeed have an impact and is relevant to this, but this adjustment is really adjusting today's rates for the shift that has occurred in the past, which is, by definition, entirely before that policy went into effect.

But I believe we did point out in the text that the estimate of the impact of that transfer policy is about 6/10ths of a percent per year and it is completely fair game to consider that in the context of this decision. That, too, is going to have an impact just as this adjustment will.

MR. JOHNSON: Just to follow up on that, aren't there also some new limits in the BBA placed on SNFs and home health agencies that might actually push sicker patients, keeping them in the hospital longer as well, so that you're not necessarily going to have what you would call that sloughing off of patients to another site? So hospitals might be limited in their ability when those people won't take those patients.

MR. ASHBY: Right.

DR. WILENSKY: This estimate has been designed to capture the effects of transfer policies in the past.

MR. ASHBY: Exactly.

DR. WILENSKY: And it is the exclusive transfer policy that will or won't capture them in the future. If what Spencer has suggested happens, that the high acuity patients and the skilled nursing facility end up spending -- having to go into a skilled nursing facility end up spending a longer time in the hospital or going to the hospital more frequently, should that happen, is there anything that is being done which would not allow for that, or are these basically an adjustment to reflect what has happened in the past and if that changes, that would change this?

MR. ASHBY: This is strictly an adjustment for what has happened in the past. Once the adjustment is made, it's over and done with. Then we, of course, in future years consider whether there has been any continued site of care substitution. I think that it's quite likely that there will not be sufficient evidence of any site of care substitution in future years and that we might fairly shortly reach the end of the line on this adjustment, but that remains to be seen.

DR. ROWE: But how does it relate to the .6

percent that you said was the effect of this transfer, the provision in the BBA, which was to address the site of care substitution? Is that .6 percent reduction in payments in addition, already in?

MR. GUTERMAN: The .6 percent that's HCFA's estimate of the effect of the transfer payment policy that went into effect at the beginning of fiscal year 1999 is the equivalent of a one-time reduction in the base payment rate that occurred in 1999, and we've taken that into account because unless transfer practice changes a lot over the years, and if anything --

DR. ROWE: Right, so you changed the baseline.

MR. GUTERMAN: So we changed the baseline and we have taken that into account in making our estimates. I mean, there's so much of a range here that that .6 percent gets easily lost in the range anyway. But it is in there. We did consider it.

MR. ASHBY: I'd like to make one further clarification in response to Jack's initial point about the variable and fixed costs. That is that when length of stay goes down, it does indeed result in some services,

particularly the cost of surgery means fewer dates and it has an increasing effect and I think that's what you were speaking of.

That's the very nature of the analysis that we've done here, is to try to capture that factor and we think that we have done so. For example, there has been approximately a 25 percent reduction in length of stay, but our estimate is that that 25 percent fewer days has only reduced costs by 10 percent, the difference being that very factor that you speak of. Some costs are still there even after the day of care is not still there.

DR. ROWE: I think that the issue, Jack, in terms of running a hospital is that some days are more expensive than others and the first days are more expensive than the last days. The transfer provision in the BBA recognizes that by for the first day of care, they count two times the mean cost for the DRG, and at the end, it's half or something like that, whatever it is.

MR. GUTERMAN: It's just two, one, one, one.

DR. ROWE: Two, one, one, one up to one DRG. So there is a recognition of that. I don't have any

disagreement with you with respect to that. My concern is just that even at the end, there are fixed costs that are not savings. They're there and they get sliced in a very thin way over all the remaining patients as things that have to get paid, I would think.

MR. ASHBY: Right. That's very important. But I think that we have done a reasonable job of capturing that in the measurement, so that what we're calling the net product change reduction is actually costs going down, the variable part of it. The fixed part of it is still there.

DR. ROWE: I'm not sure we're at risk for agreeing on -- I'm not sure I'll agree with you on how good a job you've done and you're not going to agree with me on how clear I'm being on my comments, but at least we might agree -- we'll get to that later -- that we might change the wording of this a little bit so it recognizes that there are fixed costs. It doesn't say it.

It uses this term system-wide savings, which might suggest that wasn't considered and the narrative might also at least mention the transfer that was in the BBA and how it was handled if it's been taken into consideration. Those

are the things that would improve the narrative, I think, in terms of people's understanding.

MR. ASHBY: Right, that was my first sense of response. I recognized immediately that phrase didn't capture it very well and needs some more.

DR. LAVE: We're still in clarifications?

DR. WILENSKY: Yes, because we haven't finished it.

DR. LAVE: Mine had to do with the recommendation.

MR. JOHNSON: That was a clarification of clarification evidently. Still sitting on my hands, not to get into the rest of this, are you saying -- are you inferring this is a one-year adjustment?

MR. ASHBY: This is the adjustment for fiscal year 2000. I mean, it does permanently change the base rates.

MR. GUTERMAN: But the implication is that only part of the effect that we're looking at is going to be taken out of the year 2000 rates.

DR. WILENSKY: It's phasing in a re-basing.

MR. JOHNSON: Even though we're in, I mean,

effectively with BBA even though we're in a new system, this reminds me of the ghost of the formula-driven overpayment where we finally got a handle, so we're going to go back and hit somebody with it.

MR. SHEA: But it won't work because it happened years ago.

MR. JOHNSON: Right. Where is that person we're hitting? But seriously, even though we are transitioning to sort of a new reimbursement system here, this calculation is to go back and recoup something that we think happened.

MR. GUTERMAN: No, it's not a recoupment. It's a adjustment of the base for future years to correct, in fact, that what HCFA is paying now doesn't correspond to the product that it's getting now, which is, of course, the cumulative result in past years' actions.

MR. JOHNSON: That's probably where I'm getting confused. So the past years is our rationale to do something?

MR. GUTERMAN: Of course, the 1999 payments and costs are both an accumulation of actions in previous years.

DR. KEMPER: You can tell me if it's not a

clarification. I have a technical question about the formula that you have in this appendix. You separate out scientific and technological change as separate from the through-put change. But it seems to me the way you've done this, the cost per discharge that you start with and do all the analysis with includes any effect of technological change in the past.

So it seems to me you've got it double-counted. You've got technological change in the formula that you've developed in that appendix, so it ought to be included there, at least as part of the historical evidence. But then when you come to the table you put up and the numbers, there's an additional line for the technological change.

So it seems to me it's in there twice. Am I right about that?

MR. ASHBY: The way I've always looked at it is that in the model, the right-most term will capture the effects of adjustment in these new technologies. It's basically capturing the net of productivity improvements that are achieved and additional costs that are spent on cost increases in technologies.

DR. KEMPER: Well, why doesn't that double-count the -- why doesn't the framework then, you know, when you put up all the rows that get to the bottom line, why doesn't that double-count the technological change?

DR. CURRERI: Isn't the scientific and technological advance projected new things, whereas in through-puts, we're talking about increased productivity which may have been due to past technological adoption or other formulas. At least that's the way I interpret it.

DR. KEMPER: But then you get it once in advance and then once after it's done, I mean, then again after it's done.

DR. CURRERI: I think it's all counted.

DR. KEMPER: It seems to me it's double-counted.

DR. WILENSKY: Any other clarifications? Why don't you go on and we'll come back to the full discussion.

MR. ASHBY: The case mix is next then.

MR. GREENE: Case mix adjustment is intended to adjust payments so they reflect the real resource requirements of Medicare patients. Complexity of patients created in hospitals generally goes up from year to year.

Under Medicare, case complexity is measured by the case mix indexer or CMI. CMI is the average DRG case weight for cases paid under PPS. It reflects the distribution of cases among DRGs. Increases in CMI automatically result in proportionate increases in PPS operating and capital payments.

An increase in payments is appropriate as long as CMI growth reflects real changes in patient resource requirements. Improvements in coding practices, however, can raise the CMI without increasing resource use. At the same time, an increase in the complexity of cases within DRGs can affect resource needs without a corresponding rise in payments.

CMI growth is generally moderated over time, slowing in every year from 1992 to 1994, as you can see. After a two-year rebound to 1.6 to 1.7 percent growth in 1995 and 1996, CMI growth continued to slacken, continued its downward trend to 0.3 percent in 1997.

Based on trends in recent years, we conservatively forecast CMI to continue growing at a .3 percent a year in 1998 and 1999. Recent changes in hospital coding

practices have had little effect on the growth of CMI. Since it does not appear necessary to adjust the update to remove the effect of up-coding, the precise rate of estimated CMI growth, in fact, does not affect the update as calculated.

Within DRG case complexity, reflects the severity of illness among cases classified in each DRG. It represents a dimension of case mix that is not captured by the DRG system and which does not affect payments.

Research by ProPAC found that when CMI growth exceeded 2 percent within DRG case complexity, change was about 0.5 to 1.1 percent a year. As CMI growth has decreased within DRG case complexity, change has probably declined as well. Increases within DRG complexity in fiscal year 1999 will probably be modest, and we estimate it to be equal to zero to 0.2 percent.

A combination of no adjustment for up-coding and zero to 0.2 percent for within DRG case complexity change suggests a total adjustment for case mix of zero to 0.2 percent for the update for fiscal year 2000.

DR. WILENSKY: Let me open it up. Are there any

further issues? Do you want to sum up?

MR. ASHBY: No, I think that's it. I just would point out that we have basically two things to do. One is to finalize the framework producing the range, but then secondly is to come back and craft a statement about it, what recommendation we actually want to make for the framework.

DR. WILENSKY: Now let me open it up to questions beyond clarifications.

DR. LAVE: This is going to sound a little bit like a broken wheel. I want to focus on the change and through-puts in our productivity recommendation. I think -- and I've made this point before. I think there's something terribly wrong about our framework which takes a recommendation for 15 years, which was never realized in terms of a productivity recommendation, when from every year, the through-put, in fact, increased and we held them to that recommendation.

Now, in fact, we see an increase in productivity, some of which, in fact, could have been the realized productivity that they could have had in years before and

they just got it, and now we have a recommendation that says that can be continued.

So I just sort of have a philosophical problem with sort of saying, when you can't do it, that's okay. We said you could, and when they do do it, we say, that's okay, you did it this year and you have to be able to do exactly the same thing next year in spite of the fact that you didn't do it for 15 years.

So I have a problem with the size and the way that it was done consistent with other recommendations. The other thing that I'm concerned about, and that is whether or not, given that argument aside, it actually is something that we should think about and that is if you sort of listen to some of the murmurs from the hospital industry, the murmuring, at least that I hear, is that they're currently under-staffed, everybody is extraordinarily restless, and that there are problems that maybe we have cut back more than we should have.

So I'm just wondering whether or not we -- I realize that's a self-serving argument on the part of the industry, but it certainly is a fairly loud one. So I'm

concerned, I guess, that we ought to, I think, decide one, the philosophical issues of sort of saying we get it both ways, which is the way that I read our productivity measure now.

The second one is whether or not, in fact, given the reductions in cost per case that have, in fact, taken place over the last five years, which have actually taken place, and given some of the noises at least that have come up about whether or not, in fact, we might have cut back too far, whether or not, in fact, we are comfortable with this minus 2 or minus 1 recommended change in productivity on top of the adjustment for the site of care substitution.

DR. NEWHOUSE: I'm in the unfortunate position of having gotten what I wished for. I think we should get rid of through-put. It doesn't work. My basic problem that I was trying to get at with this change was that our productivity adjustment implicitly had no adjustment for any change in quality.

So if you fired a nurse, it always looked better. You got more productive with this measure. Even if you got down to one hour of nurse for the whole hospital, you were

doing well. So at some point, obviously, you were going too far and there should be an adjustment for the change in quality that you're causing.

And in through-put, I had meant to just kind of flag the fact that if we were talking about airlines, we were talking about the equivalent of passenger miles or something like that. We weren't talking about the quality of the service you got on the airplane.

But I don't think it works, so we should just go back to productivity and make clear that there's no quality adjustment. Now, that means a couple of things. One is it means that we have to take your framework, Jack, and put in -- and we have to guess at a quality adjustment.

I don't think, for example, you're entitled to say something like aggregate performance is better than ever because that depends on what you put in for a quality adjustment. If you think the nurses are really harried and you are willing to pay for a -- I think the hospitals now have turned into the equivalent of People's Express and you are actually willing to pay for something better than People's Express, then things haven't gotten better than

ever. It all depends what you think.

So what that says to me is we're left guessing at what the productivity adjustment should be, and my own druthers would be to say, my guess would be to say rather than minus 1 to minus 2 would be to minus 1. But we can talk about that. I mean, it's kind of a question of how high do you want to set the bar for people to jump over each year, to say that kind of every day and every way, we're getting a little better.

MR. JOHNSON: I also wanted to talk about the productivity and the site of care substitution. But just a comment about the technology adjustment. We have a whole appendix in the back here on what all the new technologies are that are coming out and it goes on for, let's see, 12 pages, and there are some pretty costly things in here and I can look at some pretty costly drugs that, you know, aren't the kind that we include in the normal update factor.

But the new things and other kind of technology and procedures, and I could even add to this. But to go through that and then say there's no rationale for an update is just sort of intellectually challenging, I think, because

I think there are things there that are going to kick up the cost a little bit.

So I don't know how you want to deal with that. I don't know if you want to write 12 pages why there shouldn't be an increase to go along with the 12 pages of the new technologies.

But another point, too, recognizing the Y2K issue as well, but anyway, I don't want to carry on about it. I'd just point out that when you read the report, there's some incongruity there.

DR. WILENSKY: Is there a response?

MR. ASHBY: I think the response is, we could consider a higher number if the technologies warrant that. I was hearing some implication of that about Y2K as well, about the size of the adjustment. I think --

DR. ROWE: I'm assuming, based on what I heard -- just to follow the train of conversation, I'm assuming that there was also no increase for scientific and technical advances last year either because what you did was gave a range on zero to plus side and we've heard that Y2K was included in that.

MR. ASHBY: Right.

DR. ROWE: So if Y2K was really included in that, because that was largely to be spent in '99, and you've come up with .2, which I think was low, but anyway, for Y2K in the year 2000, then there was essentially no --

MR. ASHBY: No special provision for Y2K.

DR. ROWE: So that would mean there's two years in a row that you think there are no increases in medical technology additions, if I understand. I'm just trying to follow what we heard earlier.

MR. ASHBY: No, I think it is true. It's correct to say there was no special provision for S&TA last year.

DR. ROWE: Because we can't have it both ways. We can't have bits for that and for Y2K.

MR. GUTERMAN: Let me clarify what the S&TA means, because it's not an adjustment for the cost of technology. It's an adjustment for essentially the cost of quality increasing technology that does not otherwise increase payments. Let me give you an example.

If you come up with a new procedure that allows for the treatment of more patients than could have been

treated before because you couldn't treat patients with certain things, that generates new admissions which generates more payment, and that only the increase in cost that that technology represents above the payment that the case otherwise would have received is the part that should be reflected in the base payment rate for the case.

So this is not a statement that technology only costs .2 to .7 percent of total operating expenses. It's that changes in technology next year would be expected to raise the appropriate payment per case with the case mix factor automatically built in.

DR. ROWE: How about if I ask it this way. That's helpful, Stuart. Let's say we do it this way, because I'm having trouble understanding how we have both the Y2K and this effect in there at this number.

If we look for the previous years that we have ever used the S&TA number well before there was any Y2K effect, since the Y2K effect, we're told, was considered last year. What were the numbers that were sort of logged each year using your definition?

MR. ASHBY: The largest, I believe, was 1.0.

MR. GUTERMAN: And the smallest was .3.

DR. ROWE: So we have .3 to 1.0 and then we come along at Y2K, which was included last year, and we come out with a zero to .5, and if Y2K was .5 or .4, at least, so it was -- the S&TA was either a minus .3, you actually have a decrease -- if I'm just following -- to a plus 0.1.

That was just my point, that it's not just this year that we're saying that we don't expect it, and you may be right. I don't know if you're right or not, but even using Stuart's clarification, if we accept that historically the Commission was correct, then it doesn't seem to be -- there seems to be a reduction.

MR. ASHBY: I think it's fair to say that a year ago when we were discussing this, this issue did not have the focus that it has now and we were not really recognizing the Y2K issue.

DR. WILENSKY: What issue?

MR. ASHBY: The Y2K.

DR. ROWE: I'll accept responsibility.

MR. GUTERMAN: Or S&TA in general. In fact, if you'll recall, at the discussion last year, the Commission

focused on the bottom line, and in fact if the S&TA range had been instead of zero to .5 had been .5 to 1, the Commission's recommendation wouldn't have been affected because the recommendation was basically to that.

DR. LONG: That's precisely the point that I wanted to make, is that when we're dealing with these many components, several of which have ranges this big, and then we come out with a bottom line approach like we did last year, I think every Commissioner in his or her own mind had an implied value for each of these things that could very well have been different from every other Commissioner.

So given what we did last year, I don't know that we can conclude that the Commission, and perhaps not even any individual Commissioner, had a particular number for S&TA or a particular number for Y2K or any of the other individual line items.

That having been said, however, I am still concerned that the probable reality is that hospitals are spending substantially more on Y2K in FY '99 than any of us probably anticipated a year ago, and if we have a piece of our philosophy that says we retroactively adjust for

forecast errors, which we do with the market basket, then it seems to me that Jack has an appropriate point that we probably under-estimated this last year and that it would not be inappropriate to do some retroactive adjustment for the fact that this is not only a '99 expenditure, but will also fall over into FY 2000.

MR. JOHNSON: I actually didn't get to my main point. That was my throw-away comment. Actually what I wanted to address or focus on was this through-puts and productivity and also the site of care substitution that we developed at the last meeting, which I think is problematic.

Again, going back to the appendix, we have a real nice, long appendix on through-put, input, output, productivity, and then we have about six paragraphs in our paper about site substitution.

As far as the productivity through-put goes, I have a concern that after the number of years that hospitals have held growth flat, that in fact looking forward, even into this next year, that that's going to be a continued trend because I don't think it will be, I don't think it can be.

Also, as we sort of think about again going back to being a BBA historian and looking at policy targets and addressing issues, the BBA has $44 billion worth of policy target that hospitals are going to have to direct their talents about adjusting their productivity toward to deal with those cuts. So in essence, I think that we also address it there.

Then how that -- I'm still confused in my mind how much, if any, overlap there is between some of the things that we're looking at in these through-puts or productivity as it relates to the number of discharges and lengths of stay, and then looking at site of care substitution.

I also mentioned earlier that we have the transfer provisions, we have the payment limits on SNFs and home health, and I think we're sort of like counting twice here. You know, we broke it into two lines and I know it's only accidental that we sort of doubled what, you know, we just repeated the range on each line.

I guess, I don't know for this round or this formula, if we can take another cycle and do more work on site of care substitution since these other policies are in

effect, or somehow in also looking at productivity, we can crank the range of these numbers down because if you add them together, that's a minus 4 to a minus 1, which is a pretty big, significant part of our recommendation here. I for one think we've over-stated that.

MR. MacBAIN: Also on the productivity, or cost per case, or through-put, or whatever we're going to call it, that's the notion that in what is essentially a full employment economy, that hospital wages are going to continue to lag the rest of the economy, I think, is questionable and that by itself is going to put some buoyancy under that number.

DR. LONG: I wanted to concur with Joe's comment on the through-put/productivity and interaction with quality and think we ought to back up there, but I think I'm still basically in support of the site of care substitution adjustment.

As I appreciate it, we are not attempting to recapture past over-payment here, but merely to readjust the base to be closer to what it might have been had we contemporaneously adjusted for this phenomenon some years

past. I don't have a problem with doing that.

DR. WILENSKY: Was that clear? I think this is a serious issue and you raised it well. Do people have questions about how Hugh just stated what it is this site of care is doing? It is not attempting to capture past repayments, but rather, to state the base as it would be if we had understood the change in the product that was being delivered.

MR. JOHNSON: Well, re-basing is an adjustment retrospectively, essentially.

DR. WILENSKY: Well, we're not trying to capture what we might have taken out of the system in the past. We're not trying to go back and recoup two or three years cumulative effect of what could have been regarded as "an over-payment." It is attempting to --

DR. NEWHOUSE: Otherwise you'd do even more than come back.

DR. WILENSKY: Now, you can argue about whether what we're doing is correct, but we do, to the extent that there is agreement that it's not an attempt to capture past errors, but to state the most correct base today that we can

define.

DR. ROWE: Could you give me sort of an economist's explanation of the relevance of any -- my question about fixed and the variable costs, because even if we agreed to make that correction for what can happen, there has to be a quantitative aspect. How much of a correction can we make?

My concern from reading the narrative was that it was the entirety of the reduction in length of stay, you know, was counted in terms of the average cost per day for that DRG or something, and that seemed to me my concern was more on the qualitative aspect of this. Is that clear, Joe?

MR. ASHBY: It really was not though, because if we hypothetical, let's say, have been paying on a per diem basis and we adjust it for the full reduction in days on a per diem basis, which is by definition an average cost concept, then we would have had something like a 25 percent reduction, which is huge.

In fact, what our estimate came out to was 13. The rest is recognition that when you reduce length of stay, you cannot proportionately reduce costs because of the very

concept that you're stating.

DR. ROWE: What about the transfer, the BBA transfer provision?

MR. MacBAIN: That's future.

DR. WILENSKY: That's a future activity.

MR. ASHBY: That's future. And again, I want to acknowledge that was not taken into account in the analysis.

DR. ROWE: It's future, but it's relevant for the year we're talking about.

MR. JOHNSON: How, if you re-base it down, you're going -- you're making a correction, but you've changed the system. You have the transfer provisions, you have the payment limits on SNF and home health. We don't know what the impact of those are going to be, and your ability to maintain this sort of "site substitution" at the same rate --

DR. WILENSKY: Wait a minute. The transfer provisions only come in to the extent that you actually have transfers. If you have a hospital that doesn't have any such transfers, the plain vanilla version, this is what you face in nothing in addition. So this is trying to capture

based on past activity the best definition, and whether taking the 25 percent, which could have been if you had counted everything, and you're going to minus 13 is the right number, I have no idea.

DR. ROWE: But the site of care substitution -- we're making progress here. The site of care substitution suggests that care is occurring in two places. You're substituting one for the other. That's what that language suggests, which does suggest that, in fact, you have a transfer.

That's what this number is about. It's about those cases that went from one place to another and the transfer language in the BBA includes site, rehab, SNF, and home care as the substituted site. So it would seem to me that it is relevant. It's already counted.

It's not the people who went home and didn't have any home care. They're substituting one site of care for another and that's what this number is about, also.

MR. GUTERMAN: But the effect of the new policy that took effect in 1999 essentially takes Jack's 13 percent number and it reduces it to 12.4 percent. And then when you

take out the 4 percent that the Commission has sort of implicitly already taken out in its recommendations the last two years, that leaves you with a base of 8.4 percent, of which we're saying between 3 and 6 out of that 8.4 rather than 9 is remaining.

DR. ROWE: So what you're saying is that the actual effect, Stuart, based on the BBA -- I mean, it would seem to me it would count. It would be affected by how many transfers there were in those ten top DRGs. It's not a sort of 0.6.

MR. GUTERMAN: Right, but HCFA's estimate --

DR. ROWE: If that turned out to be none of the cases, then the effect would be zero and it that turned out to be 50 percent of the cases, then --

MR. GUTERMAN: Right, but HCFA's estimate was that in 1999, the effect would be .6 percent and if anything, you'd expect a policy like that to discourage transfer rather than to encourage more transfers. But if transfers stayed the same, then the result would be to reduce the payment rate by .6 percent and keep it at that .6 percent lower rate. So it's a one-time reduction in the base

payment rate.

If the transfer policy of hospitals changed, there would be some change from that .6 percent, but if anything, I'd expect a policy like that to discourage transfers to other institutions because hospitals would find a way to -- and the kinds of changes that Spencer is talking about would reduce that .6 percent effect because hospitals would be more reluctant or less able to transfer cases to other hospitals.

MR. MacBAIN: I think what Stuart just said turned the lightbulb on for me. If we're starting with the notion that of the observed site of care substitution we've still got this 9 percent differential that has not been reflected in the current rate, we're not trying to recapture it, we're just saying let's bring it down to the right starting point going forward.

If we fold in the effects of the BBA transfer policy, that drops that 9 percent down to 8.4 percent. So then the question is, do we then rescale, because the figures we're looking at here based on the 9 percent, should we then rescale these so that we come down to whatever it is

and we'd subtract another .6 from these or add another .6.

MR. ASHBY: Right. I would think that would be totally legitimate because that would have the same impact as --

MR. MacBAIN: I think underlying that is a certain amount of arbitrariness. The difference between 9 and 6 is out of the air, but it at least makes it explicit for ourselves when we go back and try to figure out next year what we did. Unlike the Y2K, we'll see explicitly that we included this thing in there, so if next year we add three more diagnoses, we'll know that something else has happened and we want to fold that into going forward.

MR. ASHBY: One more clarification that I think would be useful for Jack and that is when we came out with the 9 percentage points, we didn't have to measure that figure. The fact that we estimated, guessed, or whatever we want to call it, 3 to 6 of that is site of care substitution recognizing that in some cases, the reason why the patient doesn't stay as many days has nothing to do with any of these post-acute care. Oftentimes it has to do with surgical techniques that allow them to reach the point of

going home quicker.

DR. ROWE: Sure, laparoscopic surgery, different anesthesia.

DR. WILENSKY: All right, now we need to go back and you can, according to your preference, debate various lines of the recommendation or go to the bottom line. There clearly have been some questions raised about the various lines, so why don't we try, unless people feel otherwise as we go through them, the issue is going to be how -- I mean, you may want to look at both while we're having this discussion because there will be some debates in terms of specific items that when you look at the ranges will get washed away. But why we don't start at least potentially to go through these by line.

DR. CURRERI: Just a question for Jack or Stuart.

It looks to me like what's in the legislative packet for 2000, which is MB minus 1.8, isn't going to be too far off from what you're suggesting here, but it does suggest that the next two, where you're going down to market basket 1.1, it sounds to me like that's going to be too favorable an increase in costs. Is that how you see it,

too?

MR. GUTERMAN: If the other factors stayed the same, that would be the implication.

MR. JOHNSON: But again looking ahead, will hospitals hold costs flat?

MR. ASHBY: We don't know that.

MR. JOHNSON: Will we be paying more for labor? I know in Detroit right now, we're going back to paying hiring bonuses for certain kinds of nurses, and everything that we see in the field and hear is that we've hit the low point now and it's going to start creeping back up to some degree. So I don't know --

DR. ROWE: We can't even agree on what happened last year, much less this year.

DR. WILENSKY: But the point is, we don't need to make a decision about whether market basket minus 1.1 for the following year is going to be reasonable. We may well have some information from the marketplace to see that things have turned around and we can't continue the same presumption.

The big question is, when we look at a bottom line

that says a range of market basket 1.3, minus 1.3, to market basket minus 4.0 and recognize we have legislation that is market basket minus 1.8, even if we make some changes of several tenths of a point on several of these areas, it seems to me likely that market basket minus 1.8 is going to be within the spread.

So I think I don't want to in any way shut off this discussion, but in looking at it, it looks like we would have to make cumulative, very major changes to say what the legislation for this year is does not appear to be within a broad range that seems consistent with the calculations.

DR. ROWE: I agree with that, but isn't our approach, let's just do the best job we can as a Commission, more or less, eyes closed as to what and then we'll see what the BBA said in its range?

DR. WILENSKY: Actually, I thought that we were doing the other with regard to hospital, but I don't have any objection. I thought what we were doing in the areas in which there was statutory change in effect to see whether or not when we calculated it, it appeared that what was in the

statute was consistent with where we would have come out.

Well, I mean, not to basically attempt to come up with our range, although we've given the bracket, but just make sure that the statutory change was within it, but we ultimately can do both.

DR. CURRERI: But I do think, Gail, wouldn't it be good to kind of come up with best estimates for each of these items for use next year?

DR. WILENSKY: We can start back. I mean, when I looked at the bottom line --

DR. NEWHOUSE: The problem with best estimate, I think, is site of care because that's really a question about how rapidly do you phase in a re-basing and that's a different kind of call than a best estimate.

DR. CURRERI: But I gather what you're doing is sort of looking at a three-year phase-in by the figures.

MR. ASHBY: Right. But it could be a one-year phase-in, it could be a four-year phase-in. I mean, that's a different decision, as Joe says.

DR. WILENSKY: Let me go back and if people can put their hands up that would like to speak so I can get

some order in?

DR. LAVE: I would say that personally I feel relatively comfortable with the adjustment for site of care substitution. I feel very uncomfortable with the current adjustment that we've put in here for productivity and I would recommend that we reduce it for a number of reasons that I've mentioned before.

There are basically two different ones. I think the market basket forecast, which should include the change in wages, that that would be taken into account anyway, so that if the wages increase, assuming that hospitals are playing in the market with everybody else, I think that that will come up either at the time or a retrospective adjustment.

So my recommendation would be to take the market basket forecast as it stands, noting that if we're off because of tight inflation, it automatically gets adjusted. I would be persuaded to nudge up the scientific and technology advances. I would reduce the productivity, keep the site of change substitution where we are, and go with the staff judgment on the case complexity change if we were

going to stick with this formula.

DR. WILENSKY: Are you talking like one or two-tenths?

DR. LAVE: Well, I would have moved the technology one maybe up from .3 to 1 because that sounds to me as if it could be a big one. I would take the productivity actually down between minus 1 and zero.

DR. ROWE: That's what Joe said, too.

DR. LAVE: So I'm concurring with Joe. Site of care substitution I would keep where it is and depending on how I based it in the future, I would make a judgment based on what happened over hospital costs. If hospital costs jumped up a whole lot for God knows what reason, I think I might feel a little uncomfortable. So that's where I would come out.

MR. JOHNSON: I agree with Judy. I think we've understated science and technological advances and I, too, would like to see us bump that up to at least, I don't know, a range of a half to 1, something like that.

DR. NEWHOUSE: That's S&TA?

MR. JOHNSON: Yes.

DR. NEWHOUSE: What did Judy say?

DR. LAVE: I went from .3 to 1.

MR. ASHBY: Narrowing the range where you feel appropriate --

DR. LAVE: Or .5 to 1 I would feel comfortable with. I feel very comfortable with 1 on the other side.

MR. JOHNSON: I'm still concerned and not necessarily convinced on what the impact of this site of care substitution factor is going to be tied with I'm not really sure where we wound up with productivity again as it relates to what we're doing either in shortening stays or so on and so forth.

I guess I would rather spend another cycle fleshing out site of care more. I imagine that may not be acceptable to people, but certainly I agree with Judy that this productivity should come down, you know, more like -- what was yours?

DR. LAVE: I had minus 1 to zero.

MR. JOHNSON: Yes, minus 1 to zero. And I guess if it isn't the sense of the Commission to do some more thought on the site of care substitution, as we go into this

for the first time it's a new adjustment, I'd like to see that come down as well, maybe minus 1 to zero.

DR. KEMPER: Actually I'd like to come back after we agree on this, after we agree on the update recommendation.

DR. LONG: On the site of care substitution, I think just as much as a flag as anything else, we should do what we were just talking about and take some explicit recognition of what the BBA has, in fact, done on the .6 estimate. If we accept the concept of a three-year phase-in of this adjustment, then we would start from that point, minus .2 to minus .1 and bring it down a little for that 6/10ths, which would, I think, make it something like minus 1.8 to minus .9.

DR. ROWE: And then put in the narrative something about this.

DR. LONG: Yes, for institutional memory.

MR. MacBAIN: Just to go back to an earlier point, because we haven't addressed this if it's relevant, the update, all of the update for '98 was zero and I realize that wasn't based on anything. At least coincidentally,

it's very close to what the ProPAC recommendation was for that year, which was based on this same framework.

So we could look at what ProPAC did. What was the market basket forecast that ProPAC used in '98, because if it was significantly different from what actually happened, it would be appropriate to build an error adjuster in here.

MR. COSGROVE: The forecast that was used was 2.8. The actual market basket increase was 2.7.

MR. MacBAIN: So we'd have a minus .1 in here then for that, if I understand this right.

MR. COSGROVE: Yes.

DR. WILENSKY: Stuart, do you want to give a tally?

MR. GUTERMAN: According to the last numbers I heard, which would be .5 to 1 for S&TA, zero to minus 1 for productivity, and then the minus .9 to minus 1.8 for site of care substitution, leaving case mix alone, you'd come out with a range of market basket plus .1 to market basket minus -- what's the number there?

DR. LONG: You've got plus .3, I think, Stuart.

MR. GUTERMAN: Market basket plus .1 to market

basket minus 2.5. Oh, did I get it wrong?

DR. LONG: You've got to reflect the change in there.

MR. GUTERMAN: I thought I did. Maybe I added where I subtracted.

DR. LONG: You've still got the zero to .2 on case mix.

DR. ROWE: I think it becomes minus 2.7.

MR. GUTERMAN: No, it's minus 2.5. It's market basket plus .1 to market basket minus 2.5 is the range.

DR. NEWHOUSE: There's another .2 on site of care.

DR. CURRERI: Plus 1.0 or 1.1?

MR. GUTERMAN: 0.1. So the top end is market basket plus 0.1, the bottom end is market basket minus 2.5.

DR. LONG: And that's without what Bill was talking about?

DR. WILENSKY: We did not take the tenth.

MR. GUTERMAN: Right.

DR. WILENSKY: Well, we'll ignore that statement since it didn't go the direction people thought.

DR. ROWE: And the BBA's number is what?

DR. NEWHOUSE: Minus 1.8.

DR. LONG: So if we were to look at what we said last year in our recommendations that appear on page six --

DR. WILENSKY: It's actually hauntingly close.

DR. LONG: -- basically we could make exactly the same recommendation changing the FYs as appropriate and say that an update of that level is closer to the lower end of the range than the higher end of the range.

DR. NEWHOUSE: It depends on a judgment about the site of care phase-in.

DR. WILENSKY: But it is clearly within the range.

MR. GUTERMAN: How about within the range? Can we say that?

MR. ASHBY: Within the range is the general phrase?

DR. ROWE: What did we say last year?

DR. LONG: Last year we said, we observe that the statutory adjustment produced a level closer to the higher end of our range than to the lower end.

MR. GUTERMAN: We said it was within the range, but we noted that it was nearer to the higher end than the

lower end.

DR. LONG: Provides a reasonable level of payments and that it's closer to the higher end than to the lower end of the range considered by the Commission.

DR. WILENSKY: We can say now if you want it's closer to the lower end.

DR. ROWE: Whatever the rationale was.

MR. JOHNSON: Just to add onto that language on page six, though, there is a phrase, key follow-up language for last year's recommendation included although a lower update could be justified -- and I'm not sure we're saying that here -- the Commission does not believe it's necessary to further reduce.

Can the Commission make some sort of statement that the statutory update is an appropriate update so that we're not being used for some political purpose down the road?

DR. WILENSKY: Right.

DR. WILENSKY: There's nothing in the discussion, though, that suggests you could, because it's in the range -- we do not want the Commission to be regarded as saying

that we are suggesting additional reductions.

DR. LONG: But it is my intent to set the stage here that if current trends continue, and we know what the statutory trend is, that we have a two-year trend line at this point moving in a particular direction in our range, which may set the stage for a different discussion a year from now.

DR. WILENSKY: Yes.

MR. JOHNSON: Regardless of that, this year can we say that the current statutory amount is appropriate?

MR. ASHBY: Is appropriate. Then I'm stuck on the, are we saying it's within the range or do we really want to say it's closer to the lower end of the range. It seems like within the range --

DR. LAVE: Probably just say it's within the range.

MR. JOHNSON: Yes, within the range.

DR. ROWE: Many people will point out for you -- we should just do it the same way all the time to be fair to both sides, you know, and we may have chosen for whatever reason last year to make a comment saying gee, it really

looks closer to this end.

If we agree at this point that we're not going to make that comment anymore, we shouldn't make that comment anymore.

DR. WILENSKY: Jack, do you think it would be equivalent --

DR. ROWE: I think the less we say the better.

DR. WILENSKY: -- equivalent to say we think the statutory update is therefore appropriate?

DR. ROWE: Yes.

DR. WILENSKY: That would take away any specification.

DR. ROWE: I think we're better off, quite frankly, as a Commission not adding these other things, and by the way, did you notice it's closer to this one or that. I just think we should -- we did it last year. Last year was last year. I just don't think we should do it anymore because we should just say, here's the number and we believe that the legislation, that legislative number is appropriate because it's in our range. How could we say it's not?

DR. WILENSKY: Okay, agreed.

DR. ROWE: Because there's so much spin on all this stuff, I think we contribute to it sometimes. Could we ask you, Jack, also to be certain to include in the narrative, even though the reduction in site of care -- I've burned up a lot of my colleagues' time here for not a lot of change here.

DR. NEWHOUSE: We call that low-through-put.

[Laughter.]

DR. ROWE: It's one of my trademarks. Since everybody in the world knows what I make, I guess that's all right.

I think we could include -- let's make sure we include some stuff, some language about the transfer and some language about change to savings stuff so it's not misleading.

MR. ASHBY: Right, on both counts.

DR. KEMPER: We're set with this recommendation?

DR. WILENSKY: We are set with this recommendation.

DR. KEMPER: I just had a couple of comments for staff work looking forward. It seems to me there are a

couple things that this work in Appendix B is really valuable and ought to be pursued further.

One thing is this site of care substitution will continue to be an issue, particularly with the possible end of the site of care substitution coming up, and I think it would be useful to have a look at actual episodes of care, an empirical look over time including both the hospital stay and the subsequent SNF or rehab or possibly home health stay. So we look at empirical evidence as well as just the theoretical formulas that are developed.

Secondly, and I guess maybe some of this will come out in the introductory chapter that we talked about earlier, but I would like to have a clearer statement of what's the sort of logic of the adjustment, because some of the components like the market basket, it's projection with an adjustment, an adjustment or correction later.

Others are pure perspective, don't look back, and others are look back and kind of, I guess, you're updating for what you're looking back, and it seems internally inconsistent to me and it would be useful if that logic could be laid out a little more clearly.

The third thing is that I think more work, refinement of the kind of analysis that's in that appendix would be useful. I still think further thought is needed to whether or not this technological advances aren't included in the productivity estimates that are there so that there's double-counting.

And secondly, the site of care substitution and the productivity, as you point out in passing, they are not independent, so I think that leads to an over-estimate of the site of care substitution. So I just think it would be very useful to continue to work on this, maybe earlier in the season next year so we could have some of that discussion before we get into the actual recommendation. I think this is a nice advance.

DR. WILENSKY: We will try to accommodate your request. Thank you.

Let's move to the capital portion of the discussion. Tim?

MR. GREENE: We're talking right now about the capital update to the PPS inpatient payment rates. In fiscal year 1992, Medicare began paying hospitals for

capital costs based on prospectively-determined per-case rates.

The Commission's recommendation on PPS capital update is based on a framework similar to the one it uses for the PPS operating rates that you've just been through. It includes factors for capital asset price changes, an adjustment for forecast error correction, S&TA, change in productivity, site of care substitution, and case mix change.

Some of these components have different values when applied to capital. MedPAC's framework also uses a discretionary financing policy adjustment for use during periods of extended unusually high or low interest rates. I'll be going through the framework item by item.

First, the capital market basket index measures changes in the prices of capital assets that hospitals purchase. The market basket index is analogous to the one that the Commission uses in updating operating payment rates, but differs from the one used by HCFA in updating capital payment rates.

The forecast for the admissions capital market

basket for fiscal year 2000 is now 1.9 percent, according to the most recent data from DRI. The update framework also includes a correction for past forecast errors in the HCFA market basket because that's the one that was used in 1998 for setting payment rates.

It's notable here that the capital update, unlike the operating update, is not set in law, so the decisions are discretionary with the Secretary, whose decision is not law that determined the 1998 update and the Secretary will be free to act or not act on our recommendations.

The forecast market basket used in setting 1998 payment rates was 1.1 percent. As it has actually come in, the value for 1998 is 0.7 percent, which indicates minus .4 percent forecast error, which we include as a component in the update framework.

Incidentally, the adjustment for differences between HCFA and MedPAC market baskets is not relevant here. The two market baskets are completely different, unlike in the operating side where we're making -- there are subtle differences that we take account of in that measure.

The financing policy adjustment is an adjustment

for interest rate changes. At times of low interest rates, hospitals can borrow at low cost for current projects and refinancing existing debt at lower interest rates.

Capital payments should be adjusted upward and to account for the extra expense of unusually high interest rates and downward in the opposite situations.

DR. ROWE: Can I ask a question, clarification on that? The cost of financing is related to the interest rates in the market and the credit worthiness of the organization, so that if hospitals are being viewed as being less credit worthy, then they would be paying higher interest rates within the band of what the market is.

In my own personal experience, as we try to refinance, like everyone, people say, oh, God, you're an academic medical center. Allegheny went bankrupt. Are you going to go bankrupt? You know, and gee, we're real wary of, you know, knowing that academic medical centers, one of the big ones went bankrupt, which is, I guess, reasonable if you're a banker. So I'm assuming that this takes that into account.

DR. NEWHOUSE: I actually want to get into this

adjustment beyond credit worthiness.

MR. GREENE: Two specific points. First, remember this is industry-wide, not a possible specific adjustment, so we're not concerned with the relative credit worthiness of different facilities. And second --

DR. NEWHOUSE: Well, some weighted average over all facilities you're concerned about.

DR. ROWE: But it is hospitals as opposed to the nation in general.

MR. GREENE: And secondly, based on a measure of interest rates considered to be applicable to hospitals based on HCFA's research on hospital finance and reflects, as you'll see, a number of price proxies that are considered to be good for hospital financing.

DR. LAVE: I have a clarification question. Why don't we have the HCFA market basket in here as well so we can see it? Does HCFA base its recommendations on a market basket? So wouldn't it be useful for us to have their market basket in here so we have some sort of sense if there is a different number that comes out, that we kind of know where it's coming from?

MR. GREENE: The current forecast for the HCFA market basket for the year 2000 is .3 percent. That reflects the effect of low interest rates.

DR. LAVE: But is that what this 1.4 -- I mean --

MR. GREENE: No, but without the interest rate component in the HCFA market basket, their forecast would be 1.6 percent. As you'll see, we take account -- the HCFA market basket reflects both prices and interest rates. We take account of the prices through the market basket, interest rates through this discretionary financing policy adjustment.

DR. LAVE: Okay. Now, let me put it a different way then since I'm not being clear. When you come down to the bottom where you have a market basket minus something or other, can you tell us where -- we know what the market basket is?

MR. GREENE: No.

DR. LAVE: Can you tell us what the comparable changes would be using HCFA market basket numbers? So suppose that the market basket is minus 1.9 percent. We plug that in here, we get the numbers. Could you give us

some idea what the number would be if we had used HCFA numbers as the market basket?

MR. GREENE: If we combined our financing adjustment and our market basket, we'd have a number of, I suppose, .5 percent. The HCFA measure, which reflects both market basket and interest rates through fiscal 2000, would be .3 percent. It's very close. I was going to go further on the interest adjustment.

Long-term interest rates are low by historical standards. For example, for fiscal years 1996 through 2000, the forecast average of interest rates on a measure of interest paid by hospitals, a composite of interest rates, municipal bonds, and high grade corporate bonds, will be 5.36 percent. This is 1.21 percentage points below the 15-year average on the same series.

We think it's appropriate at this time to adjust capital payments for this substantial decline in interest rates compared to the long-run average. Since the capital update should reflect expected increment and capital purchase costs in a way that doesn't simply reflect transitory changes, we compare this five-year average, 1996

to 2000, to the long-run 15-year average of long-term rates.

Based on data availability, the adjustment for interest rate change at this time would be between zero and minus 1.4 percentage points.

MR. MacBAIN: Clarification? If I understood the discussion a couple minutes ago, the market basket does not include any provision for interest costs?

MR. GREENE: Right.

MR. MacBAIN: So why would we then have a negative adjustment based on interest costs later on? I can see where you might want to add something.

MR. GREENE: It should be negative to reflect that decline in current interest rates or --

MR. MacBAIN: But they're not in the market basket to begin with.

MR. GREENE: No, compared to --

DR. NEWHOUSE: I want to raise the whole issue of whether we're doing the interest rate adjustment right.

MR. MacBAIN: The other question is --

MR. GREENE: Maybe we should have the adjustment, but they reflect -- represent a substantial savings for

hospitals compared to long-run financing costs.

DR. NEWHOUSE: This is beyond clarification, it's the substance, so keep going.

DR. MYERS: Do we have any idea what the actual cost of capital is for the facilities? How closely does this proxy approximate it? Isn't that what we're doing?

MR. GREENE: This would be a proxy for the interest rate for hospitals reflecting both interest paid by non-profit facilities and interest paid by for-profit facilities.

DR. MYERS: Do we know how precisely this tracks, historically how this tracks what the hospitals actually have to pay?

MR. GREENE: I can't say for certain. It's based on many years of work, research by HCFA using large financial databases to isolate the best available measures of all available to track financing costs for hospitals.

DR. MYERS: So the answer is, no, we don't.

DR. LONG: Don't Moody's or Standard & Poor's run a hospital index?

MR. GREENE: Well, HCFA uses the Securities Data

Corporation data as part of theirs, which is corporate financial data, as one of their elements that they feed into their analysis as well as cost report data and a number of indexes that they've experimented with over the years.

DR. NEWHOUSE: My issue -- actually, I have two issues, but the first one is pretty trivial. I don't think I've ever read an explanation of what's in the capital market basket. Have we ever laid that out?

MR. GREENE: We've laid it out. We haven't been laying it out in great detail in the last several years.

DR. NEWHOUSE: So maybe in an appendix or something for the true aficionados. But the more substantive issue is, I don't think we're doing the interest rate calculations right. I think we should be using the real rate of interest because I think that that will reflect expectations about -- well, nominal interest rates would reflect expectations about future inflation, which hospitals kind of live and die with what happens in the future because that will come into the market basket over on the operating side.

And we, moreover, now have a measure of real

interest rates because of inflation index bonds or changes in real interest -- put it that way -- which is relevant. Woody's issue is really a re-basing of a capital component issue which I think may be really hard.

But setting aside the re-basing issue that the year to year change, I think we should just be using the change in real interest rates, and I think this calculation of the 15-year average is just not what we should be doing.

MR. GREENE: Change in real --

DR. NEWHOUSE: You have a calculation of interest rates from '86 to 2000 and you say the forecast --

MR. GREENE: 6.5 percent.

DR. NEWHOUSE: -- which basically says to me nominal interest rates have declined. And I don't think that's -- so what, is my observation.

MR. GREENE: It affects the nominal funds.

DR. NEWHOUSE: What you have to pay for capital now reflects market's expectations about future inflation, and the fact that past inflation has been declining is irrelevant to that. Maybe not completely irrelevant, but you can get a measure of what the market expects for future

inflation, as I say, the difference between nominal and bonds and index bonds.

DR. KEMPER: But don't hospitals get paid in nominal dollars, not in real dollars?

DR. NEWHOUSE: Yes, that's right. And what they therefore pay today -- the fact that nominal interest rates have gone down in the past is irrelevant to that. All right? What's relevant is exactly what you said, what nominal dollars will be in the future. But they'll get -- let me say this.

If inflation kicks up in the future, the unexpected, unanticipated inflation, they presumably get that through the market basket adjustment. So what I think we want to adjust for is changes in the real interest rate from year to year.

DR. LAVE: Isn't this to adjust for the interest payments that they make?

DR. NEWHOUSE: But the argument that I just made reflects that. It says that they're getting, to the degree they were wrong on anticipated inflation, they're getting the great bulk of that back.

DR. LONG: From where are they getting it?

DR. NEWHOUSE: Market basket adjustment.

DR. LONG: This market basket adjustment?

DR. NEWHOUSE: No, no. On the operating side -- most on the operating side, maybe a little bit here, too.

DR. LONG: But that's only paying for the other resources, not for the money. That's paying for the labor and the energy.

DR. NEWHOUSE: But it's sort of a measure of general inflation.

DR. LAVE: But they only pay it on 70 percent.

DR. LONG: But we're not paying them 110 percent of it.

DR. NEWHOUSE: What?

DR. LAVE: They only pay it on 70 percent. That market basket doesn't apply.

DR. NEWHOUSE: No. I said it's sort of both market baskets are going to reflect changes in inflation. But go back to the first point. The first point is that I think falls in nominal interest rates because of falls in general inflation shouldn't lead us to make an adjustment

now for the interest rate.

MR. GREENE: We're concerned with current payment, current --

DR. NEWHOUSE: We're concerned with -- we should be concerned with what hospitals have to pay now for capital and what they have to pay now reflects what the market thinks inflation is going to be going forward.

DR. LAVE: But they've already incurred all of those loans.

DR. NEWHOUSE: Yes, but that was true in the past when they incurred them and we were paying them for capital.

DR. LAVE: You're assuming that they're going to refinance everything.

DR. NEWHOUSE: Well, or if they were wrong on -- if the markets were wrong on nominal inflation, as I say, they're mostly buffered from that anyway by the market basket adjustment.

DR. LONG: A couple of things. I've got to think about whether they're buffered or not. I don't think so.

Two questions. I guess one is a procedural one. What is our trigger? From a process point of view, what is

our trigger for kicking this in? As opposed to it being an annual kind of thing, whatever the right measure is, why is it that once every 10 years we do it. I mean, how far away does it have to get from a moving average before we pay attention to it, whichever direction we're going in.

MR. GREENE: We haven't had a formal trigger in the past. In fact, last year we observed there had been a substantial decline, but we're holding off. We're being conservative before beginning, before implementing this adjustment.

DR. LONG: So is this a re-basing argument again?

DR. ROSS: It's a quality improvement.

MR. GREENE: It's a negative adjustment, so it's holding off making it, but --

DR. LONG: I understand. But it starts to sound like site of service differential or something. The second question is, it makes the assumption that either 100 percent of the debt out there is floating rate or that there's a zero cost to refinancing. Neither of those assumptions, I believe, is correct.

MR. GREENE: We're trying to estimate current

asset acquisition cost. We're not applying any of this to outstanding debt. We're calculating this as the capital costs per unit of capital for capital acquired this year, just as we're calculating the price.

DR. LONG: Now you've got me confused when you say we're only compensating for asset acquisition.

MR. GREENE: What we're trying to do is calculate both the purchase and associated financing costs of capital in the current period.

MR. GUTERMAN: Let me try and address your concern. The transaction cost issue is easy to address. We're talking about changes from year to year. So unless there's a reason to believe that there's been a change in transactions costs from year to year, you figure that a certain proportion of the capital stock is always being newly financed.

Hypothetically, in the face of a big change, a bigger proportion could be financed and that may lead to higher transactions costs in the aggregate and that would affect where on this range you stand.

Jack's point as well about the relative credit

worthiness of the hospital industry as a whole as opposed to other entities that would refinance also has to be taken into account here and would move you from the minus 1.4 toward the zero.

Now, on the issue of real interest versus nominal interest, I guess I have an easier time thinking about the other way around. If you face a situation where the long-term interest rate rises because there's some expectation that inflation is going to kick in again in the future, you might then be led to increase what you pay hospitals for purchasing capital next year based on what people think is going to happen in the future.

That may not be -- I mean, if interest rates rise, you would expect that would have a very strong effect on the price of capital, and all other things being equal, reduce the selling price of capital.

DR. NEWHOUSE: I'm willing to buy that, but that's this period's rate. I mean, when we say our method is to compare what hospitals are paying now with what they paid in the past, my objection to that is that's going to reflect what's happened to overall inflation.

MR. GUTERMAN: No, the issue is really if hospitals had the same capital -- if they were re-buying their entire capital stock under current market conditions next year, how much more would that cost them? In essence, you are always re-buying your capital stock.

So how much more would that cost them next year than it cost them this year? And that's what we're trying to capture. Conceptually, that's what the combination of --

DR. NEWHOUSE: Why isn't that just the change in the current year interest rate then?

MR. GUTERMAN: Because one might presume that they're not financing at the current year interest rate. They're financing at a longer term interest rate.

DR. NEWHOUSE: Oh, you mean the current year longer term interest rate?

MR. GUTERMAN: Because the original reason for separating out the financing policy adjustment from the market basket was that ProPAC had originally discussed it as sort of not wanting to reflect year-to-year changes in the interest rate which could be very large and not necessarily change the situation that hospitals face in terms of the

cost of capital.

So they wanted to be able to average it over. They weren't explicit about how to do that, but the implication of what they discussed was that they would average it over a long period of time so that we would only be changing things when we had reason to believe that the current cost of financing was very different from what it had been over the life -- you know, over the longer term.

DR. NEWHOUSE: So I guess I'm just disagreeing with that.

MR. GUTERMAN: Well, it's the Commission's decision about what to do about that.

DR. WILENSKY: This is what you've done in the past or not?

MR. GUTERMAN: The Commission's never made an adjustment in the past because the notion was that for the first several years of PPS capital, the market interest rates were reasonably stable and that the last several years when they've been going down, the feeling has been that they won't necessarily keep going down.

DR. WILENSKY: If we looked at the change in real

interest rates, do you know, what are the inflation-adjusted interest rates doing? I mean, what does it look like? Do you know?

DR. ROSS: It would be a very similar pattern.

DR. NEWHOUSE: Oh, no. Inflation is much slower.

DR. KEMPER: Real interest rates don't change.

DR. LONG: Real interest rates may have gone up.

MR. GREENE: Inflation is that much lower, yes.

DR. LONG: Inflation has been lower than expected as opposed to real rates.

DR. NEWHOUSE: It's not relative to expectations. It's relative to actual inflation.

DR. ROSS: CPI, as one measure, has been in the 2 to 3 range for a decade, so it's reasonable that it's about 2 to 3 points below that.

MR. GUTERMAN: One indication of the effect that it has on hospital capital expenses is to compare our market basket forecast with HCFA's market basket forecast because essentially the difference between the two is that HCFA's reflects historical interest and depreciation costs and ours only reflects the price of capital.

So one could look at the difference between those two as an indication of what changes in the interest rates have done to hospital capital costs over a long period of time. Ours is 1.9 and theirs is 0.3?

MR. GREENE: 0.3, yes.

DR. NEWHOUSE: But in principle, the cost of capital should include a depreciation component, I would have said. The cost of capital is the interest rate, foregone interest plus depreciation.

DR. LONG: Price level depreciation.

DR. NEWHOUSE: Principal is a capital gain and loss component too, here, yes, since hospitals are not normally buying and selling their capital.

MR. GUTERMAN: Every economist knows the answer to every question. It's just that they don't have the same answers.

DR. WILENSKY: We have one component. I think there is agreement on all of the components except --

MR. GREENE: All the other components are the same as what you discussed earlier.

DR. WILENSKY: All right. We'll see if we can get

some additional information about what the use of change in real interest rates would do.

DR. CURRERI: Are we reducing the through-puts?

DR. WILENSKY: We'll make it comparable to the decisions we made on the operating PPS and we'll tell you what the number is tomorrow and make a decision, the missing number is that we don't have now and then make whatever decisions we wish to. Let me correct that.

DR. ROWE: Can I ask a general question now? There must be other federal programs that use this kind of interest rate question in terms of paying for certain kinds of services or not. I mean, are we the only group in the federal government that does this? Is there another model somewhere else that we could look at?

DR. ROSS: I don't think so.

DR. ROWE: Because now we're out of the health care and we're not talking about site of care substitution stuff. We're talking about the cost of capital.

DR. ROSS: I don't know of another entitlement that pays for cost of capital.

DR. LAVE: What about utility rate-setting?

DR. WILENSKY: We'll see what the economists wing of the party can come up with tomorrow.

Disproportionate share, Jack.

MR. ASHBY: On the disproportionate share adjustment, we are basically proposing that the Commission repeat the set of three recommendations that we made last year, and in this presentation, I wanted to briefly go over a little bit of the history that we've had on this issue; then review the recommendation package itself; and then at that point, we were going to change tracks and was going to present the results of an analysis of the impact of our proposal on a specific group of hospitals, both large shares of Medicare and Medicaid payments that was done in response to a request, and we're not planning at this point to include this analysis in the March report. That would be really just for your information.

On the history and the policy context, first we have to remember that this recommendation package was initially developed by ProPAC two years ago. Congress did seriously consider the proposal at that time as the BBA was being developed. But very late in the game, they decided

not to go with the specific recommendation; rather, to require that HCFA recommend a method for distributing payments and their report was due by August of '98.

They also set some parameters for a policy in the future that I'll be going over. Also, by way of background, in the BBA, Congress also cut this funding by 5 percent to be implemented incrementally. Then six months later, MedPAC got into the act. We endorsed the ProPAC recommendation set last year and made one key refinement to it that I'll point out as we go through the recommendations.

And then finally, and rather importantly, is the fact that HCFA has not yet issued the report that was due last August. Given everything else that HCFA has had to do in the last year-and-a-half, we should perhaps not be surprised that this didn't get done, but the delay is unfortunate and, I guess, I think it will be even more unfortunate if the upcoming legislative season passes, and we still don't see the report and we have no information at this point in time suggesting that it is forthcoming any time soon.

We will, of course, review HCFA's report when it

comes in, but we tend to believe that our proposal already provides Congress with a complete policy template and we would essentially like to see the Commission emphasize that point by making the recommendations again this year, even in the absence of HCFA's report.

On to the recommendations themselves. What the package is basically about is improving the way that disproportionate share payments are distributed among hospitals. That's done in two ways: Through a better measure of care to the poor and then a distribution formula that more consistently links each hospital's payment to the amount of care that it provides to the poor. And then finally, it provides for new data collection that is needed to support the system.

Our next overhead, to reiterate an important statement that we included last year and we would propose to include again, and that is that our recommendations are based on the general understanding regarding the purpose of DSH payments that has evolved over the last few years, and that is that the DSH adjustment is meant to protect access to care for Medicare beneficiaries by providing additional

funds to hospitals whose viability might otherwise be threatened.

The implications of this are that the Commission is not endorsing disproportionate share as the long-term solution to all access problems. What we are saying is that as long as DSH represents Medicare's contribution to the access problem in the short run, then our proposal for how to distribute the payments makes a lot more sense than the system that is currently in law.

So this is an important context for the whole thing and we would say so again.

DR. WILENSKY: Can I have a clarification? When I was reading the chapter, it was not clear that if you make this statement, would you then expect to see whatever adjustment is made is such that money is given in some proportional way to the number of Medicare beneficiaries that hospitals that have more Medicare beneficiaries would be expected to receive greater payments as opposed to hospitals that might have large amounts of uncompensated care for low-income individuals, but low numbers of Medicare beneficiaries?

MR. ASHBY: Basically it does continue the per case payment, which does mean you have few cases, you get less payment. But, in fact, that comes out in the wash fairly nicely when we've done our simulations of it because those hospitals that tend to have smaller Medicare loads also tend to have large low-income shares, and the payment comes out in a way that we think is rather comparable.

DR. WILENSKY: But it would be then -- and then to the extent that it's a per-case adjustment would automatically pick up the fact that as you have increasing numbers of Medicare beneficiaries, you ought to receive additional --

MR. ASHBY: Payments should reflect accordingly, right.

DR. ROWE: Is that the way it's done now?

MR. ASHBY: That is also the way it's done now. Unfortunately --

DR. WILENSKY: Except it has floors.

MR. ASHBY: -- the amount that is paid now, we think, is off-kilter, but the concept of --

DR. ROWE: No, I understand that. I'm asking the

same question.

DR. WILENSKY: Okay, thank you.

MR. ASHBY: Then I thought I'd run through quickly the three recommendations. The first one has a progression to it. The first point relates exactly to Gail's point here. A DSH payment would continue to be made as an add-on to each case payment.

Secondly, in determining that add-on, we would base it solely on the hospital's low-income share, the amount of care that it provides to the poor, not on its location or size or any other factor. And then thirdly --

DR. ROWE: Or its ownership.

MR. ASHBY: Yes. That's an important one, too.

And thirdly, that in determining the low-income share itself, we feel that it should reflect all of the hospital's care to the poor, or specifically, the four groups that you see listed here.

The current system only includes Medicaid and Medicare as a side of patients and the BBA mandates that any future system continue to reflect those two groups, but the heart of our proposal is to bring in the last two groups as

well, uncompensated care and patients covered by local indigent care programs.

This is an important concept because by being all-inclusive, we are capturing trade-offs that exist from one state to the next. There are areas where there's a lot of uncompensated care because the Medicaid program is very weak. There are other areas where the reverse is true and we capture it all by having an all-inclusive measure.

The second recommendation has four distinct parts to it. First is the general principle that DSH payments should be concentrated among the hospitals with the largest shares of low-income patients, but it makes a great deal of difference how that general principle is operationalized, and this is where we made our refinement last year.

If we concentrate payments in a very small group, let's say a fifth or a quarter of all hospitals, then there will indeed be a fairly significant shift in payments towards large, public hospitals, but if we go too far in the other direction, basically distribute the payments among all hospitals, then our simulation shows that it does go to the wrong group. It ends up helping hospitals whose margins are

already high.

So we agreed to this middle ground that it should go to from 50 to 60 percent of hospitals. That allows many particularly voluntary hospitals with mid-level low-income shares to be helped by this program. So it's a matter of balance.

Next, we're recommending that we get rid of the notch or cliff effect. You'll remember, that's when reaching a certain low-income share entitles a hospital to a large payment, but reaching a level just a smidgen lower entitles them to nothing. So we wanted to have a smooth progression. Spencer?

MR. JOHNSON: Jack, when you talk about making a reasonable threshold for 50 to 60 percent of the hospitals and then talking about how the money would go toward everyone that had some uncompensated care, the question I have is, quite often, though, you find in under-served areas, whether it be rural or urban, hospitals that are at risk for that community for providing quality care and accessibility are really those hospitals that, I guess, have -- never mind. I read it wrong, so I just made a fool of

myself.

MR. SHEA: You got it out of the way early.

MR. JOHNSON: Those two nerve endings just went right by.

[Laughter.]

MR. ASHBY: This last line on this one, the fourth part of this recommendation is the very important notion that the same distribution formula should apply to all hospitals, and in this case, it's important to point out that in direct response to this recommendation having been made previously by ProPAC, this notion was picked up in the BBA. So any future system now must apply the same formula to all hospitals unless we are to change the law.

The last recommendation then is that HCFA should collect the data needed to implement a revised system according to these guidelines. The BBA authorizes the Secretary to collect any needed data. This simply recommends that it be done, and we provide some considerable guidance on a fairly simple approach to doing this, which involves each hospital that expects to receive a DSH payment reporting only five charge-related variables.

DR. ROWE: Jack, can I ask a question about that? Your recommendation on there is that in the future, only those hospitals that are expecting to receive a DSH payment should have data collected. I wonder if it's not such an onerous burden with respect to the reporting, as you just indicated.

It might be substantial value to understanding how much care is being provided to the poor, you know, Medicare beneficiaries.

As we look at the dynamics of the changing Medicare beneficiary population, I would think MedPAC -- that's sort of consistent with the mission, and it kind of artificially truncates the dataset by telling the hospitals that aren't expecting any DSH payment they don't have to report when it's easy to have them continue to report.

I just kind of wonder, kind of from an analytical point of view, it would be nice to have the impact data.

MR. ASHBY: I couldn't agree more. I think it would be terrific to collect those data and, in fact, the precise wording that is in the recommendation is the suggestion that we collect data from everyone initially so

that we can calibrate the system appropriately and it would also provide rich research context.

The fact is, we would love to see it collected from all hospitals indefinitely, but there's the inevitable question, such as came up with the wage index, the wage survey that went to hospitals. What do you do when the hospital simply doesn't return the survey?

At least here, you have the option of saying, well, if you don't return the survey, you don't get any DSH payment, period. At least you have that out. But, in fact, it would be terrific --

DR. ROWE: But at least if a small percent didn't return the survey, at least you would have data from '90 to '95 from 50 to 60 percent of the hospitals.

DR. MYERS: Don't all hospitals do a Medicare cost report annually?

MR. ASHBY: Yes, but the Medicare cost report does not have uncompensated care data.

DR. MYERS: Well, could this be part of the Medicare cost report? Why send out a separate report? Just make it part of the Medicare cost report.

MR. ASHBY: Yes, it could indeed be done.

DR. MYERS: Those people should know the answers anyway.

DR. ROWE: That makes it a little more onerous. What do you think, Stuart.

MR. GUTERMAN: I have two responses. One is that the original context of our statement concession that in the future, you wouldn't have to collect it from all hospitals, was a response to assertions by HCFA that it would be impossible to collect this kind of data from everybody and basically the response was, you wouldn't need it from everybody in the end. You'd only need it from the hospitals that wanted to get paid.

Certainly there's nothing that we mean to imply in there that -- we don't mean to imply that the data wouldn't be very useful and very important. In regard to the cost report, that again was a response to fears that the cost report being such an onerous document to begin with --

DR. MYERS: Five questions.

MR. GUTERMAN: I know. But the implication -- we wanted to make sure that the implication was not that

hospitals would have to allocate their costs across all these --

DR. MYERS: Draw a line at the bottom and say this is separate and different and put it on the same piece of paper.

MR. GUTERMAN: It certainly could be done.

MR. ASHBY: Precisely. If it was done that way, it would work nicely, but there was, as Hugh said, great fear that we would create a very extensive allocation process that would add a ton onto the end of the report.

DR. MYERS: Are we ready for further questions yet?

DR. WILENSKY: Is there anything additional that you want to go through before we open it up?

MR. ASHBY: I guess the question now, Gail, is whether we should discuss the analysis of the specific group of hospitals or whether we should try to finish up on the recommendation itself that would appear in the report? Perhaps we ought to finish that up.

DR. WILENSKY: Right.

MR. ASHBY: I guess the question is, does anyone

have any suggestions for additional things that need to be said or any modifications?

DR. MYERS: I do need a clarification. Hospital A, urban, small to medium-sized gets DSH payments, takes care of the poor, merges with Hospital B, suburban, large, no poor patients, in order to improve efficiencies, get their costs down, et cetera. It's a "good thing", for the community.

Hospital A loses DSH payments as a result of that, correct, if indeed their total percentages change?

MR. ASHBY: Yes.

DR. MYERS: It's a licensure issue, yes?

MR. ASHBY: Yes.

DR. MYERS: Should it be?

MR. ASHBY: The new payment would indeed reflect the combined low-income share of the two hospitals. Given the likely input of that suburban hospital, it might well take them down to a level that they don't receive it.

DR. MYERS: So doesn't that have the effect of inhibiting those kinds of maneuvers that could result in cost savings for the community and a more efficient health

care system? Should it be a licensure issue or should it be more --

MR. GUTERMAN: It also might -- the combined hospital -- since the payments would be for every Medicare patient at the new entity, if the combined share of low-income patients didn't go low enough to drop the hospital out of the DSH pool, the increased number of Medicare patients -- now every Medicare patient at both hospitals would get some adjustment.

Now, the question is the trade-off between the lower adjustment and the larger number of Medicare patients.

DR. MYERS: I don't know whether we've ever thought about that or whether that's been a discussion item before, what the hospitals think about it.

DR. WILENSKY: You get to the issue of, if you are trying to concentrate the relatively small amount of funds on the hospitals that take care of substantial numbers of poor patients, then your hospital example has done something so that it really is in a different category than a hospital that is a stand-alone low-income hospital.

MR. ASHBY: I think that's basically the answer.

That hospital would have acquired a more attractive profile of patients by payer. In other words, the very reason for it to have done the merger would be to acquire a set of patients that are going to do them well financially.

DR. MYERS: Well, no, no, don't make that assumption at all. I mean, it could be just the opposite, that the hospitals recognize that you need to serve both populations and that the community wants to be efficient in doing so. And so the leadership in that community realizes that bringing those two hospitals together provides a better opportunity to reduce fixed costs.

DR. NEWHOUSE: But Woody, suppose they now look like a single hospital that was there all the time that has the same mix?

DR. MYERS: No. Therefore they lose the DSH.

DR. NEWHOUSE: No, I understand that, but there was a single hospital there all along with the same mix as the merged hospital that didn't get DSH.

DR. MYERS: All right, but I'm making other assumptions here, that they're geographically distinct, that they're serving different types of patient populations, and

this is not something that's totally impossible.

DR. NEWHOUSE: No, it's not.

DR. WILENSKY: I think the only question is, if you want to allow for more of those types of outcomes, you can take away the threshold requirement, which means that you would automatically get something. You would get a smaller something, but it might be applied to a larger number of patients, but you will run then the danger that you'll be giving some of this DSH money to hospitals that do relatively small amounts of low-income work.

DR. CURRERI: But do large amounts of Medicare.

DR. WILENSKY: Large amounts of Medicare and small amounts of low-income.

DR. ROWE: But I didn't think that was the purpose of DSH payments. I mean, I'd be happy to talk about hospital mergers and the effects of these different incentives one way or the other sometime if people want to, but I think the idea that I thought we were talking about last year -- we had a really robust discussion about this -- was we wanted -- we did not want a disincent hospitals from taking care of poor people who are Medicare beneficiaries by

putting such a high threshold and notch effect that they say, oh, well, they're going to go to the city hospital because that's their mission and we don't get paid for any of that and we're not going to do it and that's the way the system is intended to be.

On the other hand, we have to recognize that the additional costs of taking care of DSH patients, if you will, doesn't really begin for the hospital at patient number one. You have to get to a certain proportion of your patient base before you start to have those additional costs that characterize that kind of hospital.

And so, we figured, and we got into this 50 to 60 percent, which I thought -- just trying to recapitulate our prior discussion -- and I thought we were pretty comfortable. That certainly makes sense to me.

I think there are extra costs when you get up to a certain percentage of population, but there's no reason to pay a hospital. I mean, I could give you examples. I have several hospitals, but two of them, NYU Medical Center has 3 percent Medicaid, 2 percent Medicaid because it's right next to Bellevue, and traditionally that's where the Medicaid

patients go.

Well, I don't have the program at NYU that I have at Mount Sinai where I have 25 percent Medicaid. NYU shouldn't get paid for that 2 percent. You know, it's not consistent with the DSH idea, I think.

MR. GUTERMAN: Clarification. Do NYU and Mount Sinai still have separate Medicare provider numbers?

DR. ROWE: Yes.

MR. GUTERMAN: So they would be counted separately under this?

DR. ROWE: Yes. In New York, there are separate Article 28 facilities. New York has, there are a variety of other considerations, but for now, that's it.

MR. MacBAIN: I think that's a key point, is when hospitals --

DR. ROWE: But Presbyterian and New York Hospital don't take --

DR. WILENSKY: I think that at a practical level, I don't know what else we can do other than to use that identification system to establish whether they are separate entitles or not.

DR. MYERS: Then let's ask the question then. Do those that do this every day feel it's in any way an inhibitor the way the system is set up today for mergers? If it's not, then it's irrelevant, but I would be interested in knowing whether or not --

DR. ROWE: I don't think so. My view of it is that the changes that we recommended are better for the patients and for the intention of DSH and we shouldn't worry about the implications with that. I think this is a very minor consideration --

DR. WILENSKY: In the merger discussion.

DR. ROWE: -- making these changes in institutions.

DR. CURRERI: I would think this would not be a big incentive for mergers. There are other incentives for merger that are much more important and much more cost-effective.

DR. WILENSKY: Or disincentive.

MR. ASHBY: And I should say, too, that we have heard from a lot of hospital groups over the last several years on this. Any time you reallocate payments, you're

going to hear from people and we do. We have not heard -- and we've not had anybody complain about that issue; it's never come up.

DR. MYERS: Then let me move to my second question.

Citizenship, is that an issue or has that been discussed as an issue with respect to uncompensated -- the measurement of uncompensated care, burden on a particular institution?

MR. ASHBY: No. There is nothing in the program that would give --

DR. MYERS: And Medicaid is a bit of a governor on that in that, you know, the Medicaid patient is, by definition --

DR. ROWE: But we're including, and he wants to include --

DR. MYERS: I know. He wants to broaden the definition.

DR. ROWE: -- charity and Medicare, but which would include those people who are not American citizens and those who can't pay. Right? That would be a way of getting

them in.

MR. ASHBY: The only criterion is if the hospital treats the patient and if they treat the patient, it will count.

DR. ROWE: So that would an improvement with respect to that issue than the current HCFA methodology. It might be helpful to have like a really short list of what's different about this as compared to the current way to do it rather than just in the narrative.

MR. ASHBY: It is in the narrative. There's a list of six things that are wrong with it and then we respond to them --

DR. ROWE: But we might just put in italics in the recommendations what's new or what's different.

DR. NEWHOUSE: So the big things are including uncompensated care, bad debt, and charity?

DR. WILENSKY: No notch.

DR. NEWHOUSE: And no notch, and the common -- treating everybody alike and getting rid of what's basically discrimination against the rurals.

DR. WILENSKY: Right.

DR. ROWE: Right.

MR. MacBAIN: Jack, I really appreciate having you sort of lay out the assumptions underlying this because I think that clarifies it. In putting the recommendation together, if I understand it correctly, the way of measuring uncompensated care is consistent with that, it looks at all services, inpatient and outpatient?

MR. ASHBY: Yes.

MR. MacBAIN: But unless I read it wrong, we're still distributing the funds solely on the basis of inpatient discharges.

MR. ASHBY: Yes.

MR. MacBAIN: What would happen if we were to look at all activity, which I think is more consistent with the underlying purpose of maintaining access?

MR. ASHBY: You mean the possibility of distributing the money on inpatient and outpatient payments?

MR. MacBAIN: Yes.

MR. ASHBY: If we get far enough along in our outpatient payment discussion, we do have the capability of simulating that very fact. We do have outpatient data so we

could generate some information about that if we thought we had an interest in applying this in the outpatient sector.

It has been talked about, but we haven't really moved on it in our outpatient policy discussions, but if and when we do, we could indeed generate some information for you.

DR. CURRERI: Now, are we talking though then outpatient ambulatory care, all outpatient entities, all care and so forth, or are we just talking about the hospital outpatient care?

MR. MacBAIN: I was not thinking of doctors' offices. I was thinking solely in the context of hospitals, if we're still living in a Part A/Part B world and the intent here is to support hospitals where we're concerned about their ability to continue to provide care because of a disproportionate share of poor and uncompensated.

But if that's true, then given the shift in activity toward the outpatient arena, it makes much more sense to look at the hospital as an entity rather than taking one particular slice of it that happens to involve an overnight stay.

MR. ASHBY: Right. The nice thing here is that the way this policy is set up, it could be applied to outpatient in exactly the same way as it is in the inpatient, which implicitly means we'd be treating the hospital as an entity. It would be quite easy to do if we resolve that we wanted to make such payment on the outpatient side.

DR. CURRERI: But would that give incentives potentially for the hospital to shift site to the hospital outpatient department rather than other kinds of outpatient facilities?

DR. ROWE: It would remove an incentive to admit patients who didn't need to be admitted, who were in the DSH criteria. I mean, that would be the issue.

MR. MacBAIN: It eliminates the barrier between the in-house --

DR. ROWE: Because right now the way it is, the incentive is to admit those patients to the hospital to get your DSH payment. It would remove that consideration from -- if I understand what you're saying?

MR. MacBAIN: Yes. This goes back to years ago

where hospitals were actually watching a particular patient because it had an effect on this.

DR. CURRERI: But the other side of the coin is that in many cities, taking care of the poor, the hospital acts as an inpatient, but there are other clinic facilities not a part of the hospital. We specifically look at Medicaid patients and those uncompensated and it might deter, even though those may be closer to the patient's home and much more accessible to the patient, it might deter them not to refer them there, but rather, to the outpatient department in order to get more credit.

MR. MacBAIN: For somebody who would obviously not be admitted anyway, yes.

DR. WILENSKY: I think for this year, the issue about what over -- I mean, I think this is an issue that we ought to take up for later discussion.

MR. GUTERMAN: One clarification point. The system that is on the table now, the proposal, doesn't -- making payments subject to both, on inpatient and outpatient would not affect the incentive to admit poor patients to the hospital because the proposal that's on the table now

already counts poor patients, both in the inpatient and outpatient setting, and the payment gets made on every Medicare patient.

So if anything, there's an incentive to admit Medicare patients to get this payment.

DR. ROWE: I see. I do think for those, the non-economists, it's really important for everybody to understand that if you went to our outpatient department and you talked to the people making the decisions about whether the patients get admitted to the hospital or go home or get home care or what, they don't know what DSH stands for.

They hardly know what Medicare stands for. I don't want people to get the wrong impression who are not involved in clinical medicine that the doctors and the nurses -- that we sent a memo down, you know, Jack says admit all the DSH payments and all the DSH patients get admitted.

First of all, if I ever told them that, that would guarantee that none of the patients would get admitted.

[Laughter.]

DR. ROWE: You don't tell them how to practice

medicine. It would also guarantee that it would be in the front page of the Daily News the next day. But the people taking care, we sometimes talk about incentives in this Commission, and I think it's appropriate to talk about it, but sometimes we overdo it in terms of thinking that we're incenting a nurse or a doctor when we're really not.

MR. JOHNSON: So DSH is a retrospective gratuity.

DR. WILENSKY: Can we quote you on that?

[Laughter.]

MR. ASHBY: Do we have it resolved that we do want to make this set of recommendations again in the context of we haven't yet heard from HCFA?

DR. WILENSKY: Yes, right.

DR. MYERS: Why is that, by the way?

MR. ASHBY: I think it has more to do with their workload than anything else. They did start to work on the report and then the person that was honchoing the project left HCFA and that very practical concern left it sitting on her desk with no one to work on it and everybody worrying about managed care issues.

Now we have a second part of the presentation. Do

we want to go ahead and move into that?

DR. WILENSKY: Is it going to be in our report?

MR. ASHBY: No, we are not proposing, based on the findings of the analysis, to include it in the report.

DR. WILENSKY: I think that we ought to have people --

MR. ASHBY: Do you want to put this off until later?

DR. LAVE: It's in our document, right?

MR. ASHBY: Right.

DR. WILENSKY: Unless someone has something very specific they want to raise, do so. Otherwise, I think we ought to open it for public comment.

MR. ASHBY: Okay.

DR. WILENSKY: Let me open this now for public comment on any of the discussions that we've had with regard to hospital updates, capital, operating, DSH, et cetera.

MS. COYLE: Carmela Coyle with the American Hospital Association. I wanted to support the Commission's recommended language that I think very clearly puts into context the congressionally-mandated level for Medicare

inpatient PPS and the context of your discussions this morning.

My second point, I guess I would like to appeal to the Commission very sincerely and very genuinely on the issue of the site of care substitution adjustment; that if this is an adjustment that the Commission intends to use over time, that that is an adjustment that is really tried to, in terms of methodology, to be developed more rigorously.

I think this Commission knows that for every one percentage point in that update amount, that that translates into $1 billion in one year alone in terms of payments that may or may not be made to hospitals by Medicare, depending on what Congress ultimately decides.

Having said that, I think there are three areas of concern and there's been a lot of discussion about it this morning already. Personally, I wonder about this year being the first use of a site of care substitution which is precisely at the same time that we have some new laws put into place as part of the Balanced Budget Act that will, in fact, affect the site in which patients receive care.

What I worry about is, I think about things called turning points. Are we putting this adjustment in at a point in time when we may actually be seeing a turning point in terms of this whole issue of site of care substitution.

Second, you talked earlier about an explicit adjustment for the transfer provision. I would suggest you might consider an explicit adjustment as well for the new SNF PPS system and the new home health payment changes, which I believe could have a more significant impact on the site of care than even the transfer provision.

And third, I had a real hard time getting my head around the site of care substitution adjustment, and I've been sitting back here sort of scratching my head. I think I finally figured it out and that is, I'm having a hard time understanding what it means to make this adjustment in the context of the update factor where the update is about how much more Medicare will pay next year compared to this year.

What we're talking about it looking at change in length of stay over time and that the product is now different, and I think what starts to confuse me as I try to mesh those two things is, what about all those years when

Congress enacted update levels that were lower than what MedPAC recommended? Kind of, has this already been taken into account?

I think it's the confluence of MedPAC's recommendations in the context of what Congress actually does. It probably would be less confusing if Congress enacted what you all recommended each year. The framework sort of serially over time makes more sense. I think it goes to Hugh's point.

If this is going to be a three-year phase-in, it kind of depends what Congress does. I don't know if that's helpful. It's sort of been helpful to me in thinking about why it's so confusing to think about it in these terms, but if we can be of more help, something to consider, whether it's experts from the field, other folks in the policy world in terms of developing that methodology, we'd be more than happy to help. Thanks.

DR. NEWHOUSE: I think you got the concept right, and if you have any -- if you think the text discussion could be modified in some way, that is, if our discussion helped you for something that you didn't get in the text,

I'm sure the staff would be happy to get suggestions.

MS. COYLE: I haven't seen the text, but we'd be happy to check it out.

DR. NEWHOUSE: Oh, you haven't seen the text. Okay.

MS. COYLE: We'd like to see the text.

DR. NEWHOUSE: It will be redrafted.

DR. ROWE: What she meant to say is she'd like to write the text.

[Laughter.]

MR. SHEA: The point about the discordancy in what we recommend and what Congress adopted may be something that we could put in the conveying later. By the way, people have been complaining.

[Laughter.]

DR. NEWHOUSE: But what the Congress did was within our range last year.

MR. CALLEN: Mark Callen, Health Care Association of New York State. I'm not going to repeat all the same things that Carmela said, although I do agree and support her comments on the site of substitution. I'd like to make

one other comment in that particular area.

It worries me a little bit if in your March report you actually have a section on this and you have a number in there that says that MedPAC has estimated this impact to be minus 3 to minus 6 percent, because I believe -- I agree with Carmela that if this is going to be something that you are going to include every year, it really does require more rigorous analysis.

I think that it can be done. I think that you can go into the standard analytic files that HCFA provides. I think you can come up with a data-driven number, and I don't know what that number will be, but it worries me if you come out with such a large number without doing that kind of rigorous analysis.

DR. NEWHOUSE: Thank you. We'll take a break. No, we won't take a break. We'll go on to Jim Mathews and ambulatory care facilities.

MR. MATHEWS: Good afternoon. This morning in executive session, Joe mentioned you felt you had hammered out the ambulatory care venue fairly well over the last few months. As the anvil in that process, I'm particularly

appreciative.

[Laughter.]

MR. MATHEWS: As Murray indicated, it might have been a function of time rather than staff knowledge or effort or that kind of thing. I am willing to yield any remaining time I have to my more worthwhile colleagues at this point.

Seriously, though, since we have discussed the background of our ambulatory care recommendations at some length over the last few months, it might be worthwhile just to briefly recap what we've said and why we've said it, and if you have any questions on the technical background, we can make it up as we go along.

We came up with ten recommendations for the March report on ambulatory care. They fall into three categories. There are several that we believe apply to all ambulatory care settings, as a matter of general principle; several that pertain to the specific proposal for hospital outpatient prospective payment that HCFA published in August or September of this year, in the fall of last year; and we have a single recommendation specific to HCFA's proposed

changes to the ambulatory/surgical center payment system.

The first of our general recommendations deals with the unit of payment. This is basically defining the package of services or the bundle of services that the payment is intended to cover.

In discussing the unit of payment, we had two competing models. First was the inpatient model where the payment covers a broad bundle of services, basically everything that happens during the course of an inpatient admission. The competing model was the approach used in the Medicare fee schedule for physician services where the unit of payment is much more tightly defined.

On the basis of our previous discussions, I believe that the Commission has recommended a more tightly defined unit of payment for ambulatory care in general since the nature of the services provided are more close to that provided in the physician setting than in the hospital outpatient setting.

There are a number of other reasons that are provided in a little bit more detail in the chapter.

DR. CURRERI: Could I ask you a question about

that? I'm not sure, on page eight in the second paragraph there, there's nothing untruthful about it, but maybe you could answer this question for me. Surgical services provided in an outpatient department are still bundled, are they not, as far as follow-up care?

We keep talking about a single, individual service. But if you do a cholecystectomy in an outpatient department, I don't know if you want to do that, but it takes something less. I guess it would still be under the three-month bundle or whatever, and if so, perhaps we should modify that paragraph. If you could check on that?

We might also modify the -- if that is true, then you could modify the recommendation by adding, in the book, something like and limited follow-up care for surgical services, or something like that.

I just think that we ought to know whether, in fact, those are bundled because it sounds like we're only going to pay for the procedure that was done.

DR. NEWHOUSE: I think you're correct. I think they are bundled.

DR. LEWERS: Joe, are we going to discuss the

recommendations later?

DR. NEWHOUSE: Yes. This was supposed to be clarification.

DR. LEWERS: I've got a clarification. I'll take my shot while I can get it.

I think it's along the lines of what Bill is pointing out, because when you read some of the narrative, it talks about physician services, office services, analogous to office-based services. We're talking about prospective payment for ambulatory care. We're not talking about physician services.

DR. NEWHOUSE: Correct.

DR. LEWERS: That's the point that Judy brought up a while ago that was getting confused. If you read the narrative and read this, I can interpret this to mean that you're talking about not only bundling supplies, but bundling physician services. I think this has to be clear.

MR. MATHEWS: Right. It was not my intention to convey the idea that physician services would indeed be bundled here. We are just talking about the facility payment.

DR. LEWERS: What I'm saying --

DR. NEWHOUSE: He's saying he wants that explicit.

DR. LEWERS: I want that explicit, right, whether it's in the recommendation or not. But you talk about services integral to it. That could be physicians. So if that's not what you mean, then you need to clarify that.

DR. ROWE: I think that's going to become more important, too, as more of these complex services are done in the outpatient department. We currently do now in the outpatient department things that I never thought we would. The most recent example is bone marrow transplant patients. Whoever dreamed that a patient with a bone marrow transplant would never be admitted to the hospital, but that's not rare at this point.

MR. MATHEWS: I can make sure that that's clear in the text and the recommendation.

DR. LEWERS: Thank you.

DR. LAVE: Where do they go after to be --

DR. ROWE: The biggest program is at Duke and they go to a kind of hotel-like facility not far from the medical center where they get their white count checked and stuff

like that. Hospitals are dangerous places for people without any defenses, and it turns out you can do this. It sounds bizarre, but it is actually done and it's done with great expertise and good outcomes. So there's an example.

MR. MATHEWS: The next recommendation deals with the calculation of the relative weights. The discussion here was whether weight should be calculated on the basis of discretely coded individual services in much the same way that they are under the Medicare fee schedule or using a grouping mechanism as proposed by HCFA, the ambulatory payment classification system.

This is a different concept from bundling in that bundling affects how the unit of payment is defined. Grouping mixes discrete services that are defined according to the same payment unit. Grouping, we believe, has the potential to distort payments for services if the ones that compose each group are not homogenous.

Your prior discussion suggested that while grouping may not be objectionable, per se, that the details in this particular implementation proposal haven't been worked out, nor is grouping being proposed for the physician

office setting. Therefore, at this point, we make the recommendation that under the outpatient PPS, the relative weight should be calculated based on the individual HCPC's coded services.

The next general recommendation is payment consistency across settings. This recommendation deals with the fact that because of historical payment policies, Medicare does indeed pay different amounts for the same service depending on which ambulatory setting it's provided in.

Under the proposed changes that are occurring in the hospital outpatient, the ambulatory surgical center, and the physician office setting, Medicare will continue to pay different amounts for the same service. Previously, you've expressed the idea that all else being equal, differences in payments amongst settings should only reflect differences in relative costliness of providing services appropriate to the needs of individual patients.

What we're saying with this recommendation is that HCFA should begin to evaluate differences in payment across settings once the new systems are in place to ensure that

unwanted financial incentives are not created and to move towards a more consistent approach.

A logical follow-up to that recommendation is the issue of payment adjustments across settings. If we find that part of the reason that the continued differentiation of payments for the same service among settings is attributable to the patients that these facilities treat, it may be possible that we can develop an explicit adjustment system to recognize the fact that the differences in payments do reflect costliness of the individual beneficiaries.

If I understand your previous discussions, you do believe that such an adjustment system should apply across all ambulatory settings. I might have mistaken that perspective given your discussion of DSH just a moment ago. We can come back to that momentarily, though.

The next recommendation deals with controlling ambulatory care spending. One of the problems with the pre-BBA payment methodology for hospital outpatient services was that there was no incentive for hospitals to control costs in providing outpatient care; that the higher the hospital's

reported cost of providing these services, in general, the higher its reimbursement from Medicare would be.

So you might even believe that there was an incentive to increase reported costs in the outpatient setting. The BBA directed HCFA to implement a control on hospital outpatient spending. At our last meeting, you expressed the idea that such an expenditure cap would be more effective in reducing the silo approach to Medicare payment for ambulatory care if it applied to all ambulatory settings; hence, the language in the recommendation that appears in the draft chapter.

DR. CURRERI: I'd like a clarification on that. I mean, I agree. This is what we said, but a single SGR system I can see could be set up and would encourage migration of services as appropriate between outpatient and ambulatory settings.

But I fail to see how the SGR system would have anything to do with the movement of inpatient ambulatory settings, because by definition, if you have an SGR, you could conceivably say that it does, in fact, restrict inpatient to outpatient because of the fact that you don't

want to have a high volume.

DR. NEWHOUSE: I'm going to say that's more than a point of clarification. You're right and we'll go on and talk about it later.

DR. KEMPER: Can I ask you a point of clarification? Does the law mandate sustainable growth rate or just some kind of volume control?

MR. MATHEWS: It's not extremely specific.

DR. LEWERS: Clarification. Here you use physician fees. In the recommendation in here, you use physician's practices. What are you talking about? Are you using fees? Are you using volume?

DR. NEWHOUSE: I think we mean payments.

DR. LEWERS: What volume are you talking about?

MR. MATHEWS: Our discussion at the last meeting suggested that the entire physician fee schedule would be brought into this system.

DR. NEWHOUSE: But the SGR would, in principle, apply to physician plus outpatient payment.

MR. MATHEWS: That's correct.

DR. CURRERI: Not the entire amount. I mean,

including the inpatient fees?

MR. MATHEWS: We did have this explicit discussion last time.

DR. NEWHOUSE: Yes.

DR. LAVE: We didn't think about the inpatient part.

DR. NEWHOUSE: Yes, we did.

MR. MATHEWS: We also had it in executive session last time. This issue was raised at some length.

DR. NEWHOUSE: But the clarification -- it's clearer probably in the recommendation to say including physician payments or physician spending or physician expenditure or something rather than fees. I think that was the point that Ted was raising.

DR. LEWERS: Yes. I'm not clear what you mean.

DR. NEWHOUSE: Am I right? That's my recollection of the discussion. Let me say it that way. We meant dollars being paid out, which the SGR would apply to. We can come back to just what defines those dollars in the inpatient side.

MR. MATHEWS: I can make this say whatever you

want.

DR. NEWHOUSE: I understand. But again, this goes beyond clarification.

MR. MATHEWS: Next recommendation, please. This one is specific to HCFA's proposal for the hospital outpatient PPS. One of the characteristics of it is that for non-procedural services, for E&M visits, for the most part, HCFA uses the ICD-9 diagnosis code that appears on the claim at the time the service is provided in order to differentiate intensity of services, and it's sort of a proxy for the patient level adjuster that we've talked about previously.

Based upon our previous discussion, you've suggested that again the specifics of the implementation are not such that we believe that it is a reliable approach at present. There are some serious questions about the validity of the diagnosis coding data in the hospital ooutpatientsetting, nor are the guidelines for coding, once the system is implemented, have been fully described.

Therefore, your recommendation was that HCFA should not use diagnosis to stratify payment for E&M

services, but rather, calculate the relative weights and make payments based solely on the HCFA-coded medical visit.

DR. LAVE: Could I ask -- I think this is a clarification question and this gets to the consistency issues, and that is that in the evaluation and management visit in an outpatient department, are there different sets of services included in that visit than there would be in an evaluation and management office to a physician's office?

I mean, are there different kinds of things that are included? So the question is, why, if it was not found worthwhile to have -- I think this has to do with sort of trying to make sense of what happens in the thing. So I think it would be useful to know whether or not the bundle of the services included in the E&M visit is conceptually different in the outpatient department than it is in the physician's office.

DR. NEWHOUSE: You mean is it different in the classification system or in practice?

DR. LAVE: Well, if I say I have an E&M visit, what is included in that visit? Is the same thing that I would include in that visit if it's in an outpatient

department the same thing as would be included? If the answer to that is no, I guess I'd like to know why. If the answer to that is yes, then one would ask about the diagnosis in the physician's office as well. I don't know if we want to go down that way, but I think we've been trying to clarify what's going on here.

MR. MATHEWS: I think I understand the question. As I understand HCFA's current proposal, the unit of payment that they have defined that would take effect on implementation is similar to that which applies to the Medicare fee schedule in terms of the bundle of services that is included in the payment.

There are limited supplies. The indirect costs that the facility incurs, you know, electricity, that sort of thing, the indirect labor costs, staffing, reception, nursing, the same sort of things that the physician's office incurs.

Under that unit of payment, if you stratify the HCPCs coded medical visit by diagnosis, you don't get a lot of differentiation from one diagnosis to the next. If you start increasing the unit of payment to include ancillary

services such as imaging, laboratory, radiology, other types of diagnostic services, that is where you start to see the differentiation according to diagnosis.

DR. LAVE: Well, that's the question that I had is, does your E&M visit include all of that other stuff or is all of that other stuff included under a HCPC other grouping system.

MR. MATHEWS: Under HCFA's proposal, as it stands now, those other ancillary services are not included in the bundle. However, that is their long-term goal because they believe that part of the growth in spending is attributable to the increase in the number and intensity of ancillary services that are provided in conjunction with hospital outpatient visits. So they see this as sort of a means of volume control and it is a long-term objective of HCFA's under the outpatient PPS.

Finally -- not finally, sorry. Wishful thinking. We have a recommendation that sounds somewhat general, but it's hopefully more significant than it sounds, stresses the importance of modeling utilization of ambulatory services once these new systems or revisions to existing systems are

put into place.

Basically what we've done is thrown all the balls up in the air and we aren't certain if they're all going to be caught coming down or where they will land. This basically is a heads-up to monitor what may or may not be inappropriate shifts in setting that could be attributable to payment incentives or disincentives to ensure that payments are sufficient among all of these settings to maintain appropriate access to care and so forth.

Within the hospital outpatient proposal that HCFA has published, they recommend making only a single adjustment to the payments, it's a wage index adjustment, to recognize differences in prices attributable to labor. Following as a subset of the general principle, adjustments may be warranted on a patient level basis across settings.

We believe that the same principle applies within settings and that therefore among different classes with hospitals, that payments may be adjusted to reflect relative costliness of providing services to beneficiaries. We do recognize that such an adjuster is not currently available, nor is it likely to become available by the time HCFA will

implement the outpatient PPS.

Therefore, we recognize that a facility level adjuster may be necessary to preserve access to special populations under the new system, provided that such adjusters are specifically tied to the cap characteristics of the beneficiary population that such facilities treat.

In the recommendation language, we do indicate that it is with some trepidation that we make this recommendation because once such adjustments are in place, they're often difficult to replace or abolish as appropriate in the future.

We have a recommendation which reiterates a bit more strongly a recommendation we made last year regarding the beneficiary co-insurance liability for hospital outpatient services.

As you'll recall, as an artifact of prior law payment policy, beneficiaries pay or are liable for about 50 percent of the total payment to hospitals for outpatient services, compared to 20 percent for most other services.

The BBA does correct this inequity. Hopefully by the time I am a beneficiary, I will be paying 20 percent,

which may be too long, or we've indicated that it is too long and it should be brought down more quickly than specified by the BBA.

We've indicated that we believe the additional cost should be borne by program spending rather than additional reductions in payments to hospitals.

DR. ROWE: Can I ask a question about that one? I think that's accurate. It reflects the discussion that we had previously, as I recall, and actually the document, the narrative doesn't include it that way.

The recommendation, per se, which is on page 20, says the current rate will take part to reach the desired goal and that beneficiaries will continue to pay the disproportionate direct and indirect costs. It doesn't include the second part of the recommendation that you just included on this overhead.

DR. LEWERS: It's in the narrative part. I agree. I think it should be moved up.

DR. ROWE: It's two paragraphs down, but I think we had this discussion before.

DR. WILENSKY: We did.

DR. ROWE: So let's include it in the recommendation.

DR. LEWERS: Let's take this recommendation. That's a clarification.

DR. ROWE: That was a clarification, laser-like.

DR. NEWHOUSE: I agree. It was laser-like.

MR. MATHEWS: Finally, we have a single recommendation related to the changes that HCFA has proposed for the ASC payment system. As you'll recall, under Medicare coverage rules, ASCs are limited in the services they can provide to Medicare beneficiaries based on certain percentages of the provision of services in other settings.

HCFA has proposed loosening those numeric guidelines somewhat, and what we want to be sure is that we don't see shifts in setting, particularly from the physician office setting to the ASC as a result of these guidelines. Just a monitoring recommendation.

That's it. We can open up the discussion.

DR. WILENSKY: Now, should we go back to the first recommendation?

DR. CURRERI: On the first recommendation, I

think we just need to be very clear that what we're talking about essentially is costs of supplies and costs of rooms and so forth and the recommendation to me sounds like it also -- and I read it as including physician services and I don't think that's what it's meant to be.

MR. MATHEWS: That's correct. I never intended it to.

DR. KEMPER: Do you have a specific change?

DR. WILENSKY: This is on page seven.

DR. CURRERI: I wonder if you could solve that by saying it should consist of the primary facility services, or something of that sort, so it doesn't sound like the physician services.

DR. LEWERS: Facility, ancillary supplies and services?

DR. CURRERI: Yes.

DR. WILENSKY: Any other comments on this or the next recommendation?

MR. MacBAIN: Just before we get too far along. One page nine of the narrative, there's a statement that says -- in the first paragraph -- whether services provided

in an OPD, physician's office, or other free-standing facility now depends more on the shingle over the door rather than the nature of the service.

I think that's a little too general. There's a fair dimension and that's the nature of the patient that probably is determinative of where the service should be provided. We're implying a homogeneity of service across those three settings that I don't think is true.

MR. MATHEWS: What I was trying to get at is addressing the issue of hospitals purchasing physician practices and operating them as outpatient departments. We hear anecdotal evidence that this has occurred or is occurring. But the nature of the actual facility, whether it's a large group practice, small office, doesn't change. It's simply being operated by the hospital. I can revise that.

MR. MacBAIN: Our recommendation is to have, lacking of some sort of patient measure that indicates degree of severity or complexity, at least in some sort of facility indicated that recognizes that in aggregate services provided in OPD and services provided in a

physician's office tend to be different and have different cost patterns.

DR. WILENSKY: The recommendation on page nine, which is the cost of individual services. Okay, page 12?

DR. LAVE: What page?

DR. WILENSKY: Page 12. Sort of the gist is up on the slide, but if you want to look at the actual wording in the recommendation, which is a wise thing.

DR. LEWERS: I would recommend we consider, this talks about the payments, et cetera, and then at the end, it says where relevant to ensure that unwarranted financial incentives are not provided. I think we've got better language on page 13 in the middle of the page, and I would recommend where we have unwarranted financial incentives, that we add the language that could inappropriately affect decisions regarding where care is provided, and even consider putting that next sentence in.

I think this is much clearer than financial incentives are not provided. So if we took -- they're not numbered, but if we took the above where it says payment adjustments across settings, go up one, two, three, the

fourth line where it says financial incentives, take the rest of that sentence, put it in there, and then where those are found, that they should recalibrate. I would recommend that we add those two sentences.

DR. WILENSKY: When we're looking at revised recommendations, can we just see what that looks like? I think that would help us all. Thank you.

DR. LAVE: Are we still on this one?

DR. WILENSKY: Yes.

DR. LAVE: Then I'll wait.

DR. WILENSKY: Are your comments about this one?

DR. KEMPER: Yes. I agree with that, and just more generally throughout the document, it seems financial incentives is used a lot in a very indefinite way without saying whose incentive and to do what. I found it hard to understand what the point was being made.

Particularly when most of the decisions are made by physicians concerning setting, you have to be clear about who is it that's being affected by what incentives. But Ted's change certainly clarifies this in a way that makes it a lot clearer.

DR. NEWHOUSE: I wanted to come back actually to the prior recommendation and the text language about it and HCFA's arguments about why they want grouping. Their first argument is that to calculate weights for low-volume services, they couldn't be very precise about this. This is on page ten of the text.

It seems to me that same argument applies to physician office visits, so I'm not sure why they're comfortable in one case and not the other. Then they say this will discourage up-coding, but up-coding seems to be less of a problem with the SGR there. I'm not quite sure why up-coding is a very big consideration here. Do you have any insight into either of those arguments?

We wind up saying on balance, we still favor this, but we don't directly take on these arguments.

MR. MATHEWS: I could. On the first one, the methodology is to construct the relative weights and the physician fee schedule is very different than that which is being used to build up the weights under the outpatient PPS.

Under the practice expense, as we've heard previously, they're being built up through a normative

process, whereas in the outpatient setting, they are being built by sort of deconstructing aggregate hospital level data and applying it down to the actual claims.

In a lot of cases, they simply do not have any claims data to apply the hospital aggregates to, so you get blanks for the values. Given no aggregate data --

DR. NEWHOUSE: I guess I don't quite understand how they're doing this deconstruction, but maybe --

MR. MATHEWS: I believe it's a legitimate method of estimating the hospital costs. We have used the same method, more or less, here. We haven't made the leap that HCFA has and inferred or imputed values for services for which we have no utilization data, and that's part of what grouping does.

DR. WILENSKY: Judy, did you have a comment?

DR. LAVE: I had a comment here that falls under the monitoring system, but it seemed to me that we may want to discuss it here, and that is, it falls from the following concern and we've talked about that, but I haven't seen us discuss it here.

We have diagnosis, let's say a colonoscopy, and we

have a price for that in the physician's office and we have a price for that in the outpatient department, but it's never done in the physician's office. So we look at these two things and we say, oh, my God, they're different. We ought to get upset about that.

So I think that when we're looking for the payment amounts and trying to see how similar they are, you don't want to do it only by the code. We want to do it by some idea about whether or not we're really comparing services for which there actually is practices in both sites.

DR. NEWHOUSE: But Judy, suppose there was a big payment difference and it was 100 percent done in the high payment site. So how would we know whether that's for technical reasons or financial reasons?

DR. LAVE: But you can use -- I mean, we're not stupid, Joe. I mean, it seems to me that if you have something that is 100 percent done in the high payment site and last year it was done 100 percent in the office, then I would be very concerned.

But, you know, it just strikes me that if that happens, then we would know that that had happened because

we would have known that last year it was done in the low payment setting.

DR. NEWHOUSE: But suppose it wasn't, but suppose you -- how would you know? I don't think you can, but suppose some things would migrate out toward --

DR. LAVE: I don't think that's going to be a problem.

DR. NEWHOUSE: Suppose things would migrate out toward the office in some kind of "neutral" payment system, but if there's a big payment differential, they won't.

DR. LAVE: Well, maybe you could get some form of clinical insight into things that look as if they ought to have migrated and they haven't. I just sort of am very much concerned --

DR. CURRERI: If you had a uniform SGR, would it make any difference?

DR. LAVE: -- about comparing absolute differences and spending a lot of time worrying about it when it may not be relevant.

DR. NEWHOUSE: Not to Medicare, but to providers and beneficiaries.

DR. WILENSKY: Are you suggesting that there's some sort of either clinical assessment or just practical or just assessment, a numeric assessment about whether these actually occur?

DR. LAVE: I'm assessing that when we say they ought to be compared, that we ought to put the effort to comparing those things where it looks as if, in fact, there could be significant overlap or there is a significant overlap.

We don't compare them if it's like 90 percent in one site and 10 percent in the other, because otherwise, we may spend a lot of time thinking -- we looked at some of these cases last time, it seemed to me, and there were big payment differences and they were never done in the physician's office.

DR. CURRERI: I think, thought, you could compare that because let's take your example, colonoscopy. I have probably done in ambulatory -- it's done in ambulatory outpatient departments and in ambulatory surgical centers. So you could compare those two.

DR. LAVE: Right. But we're going to have a price

for a colonoscopy in the physician's office. My guess is, if we go and look in the book, we will see what the technical component is for doing a colonoscopy in a physician's office, and it's going to be much lower than the other one. They say, oh, we've screwed up the payment, but yet it's not relevant. That's sort of the point.

DR. NEWHOUSE: But we have a thing coming up, an example of this in the physician chapter where this argument about well, it's not safe to do it in the office. Well, okay. But suppose you got better at it so it became safe. I mean, we've had all sorts of stuff migrate to outpatient that 15 years ago people would have said it's not safe.

Now, there's a specific thing about this kind of the safety criterion, but there's also an issue about the payment system getting in the way. I mean, I understand what you're trying to say. We should make real comparisons.

DR. LAVE: We have to make real comparisons and for some of these things, the dollar sums are going to be very different, and it may be that, in fact, they would never be able to do it in the physician's office at the price that we have it.

DR. CURRERI: I think the safety factor is in the amount of anesthesia, the monitoring of heavy tranquilization, which is required. I don't know how you get around that unless you hire people like nurse anesthetists or something to monitor these people, and that's probably not going to be any cheaper.

MR. MATHEWS: Judy, in the next chapter on physician payment issues, there is a recommendation that does address clinical appropriateness.

DR. LAVE: But I think -- I mean, I'm only saying we have this recommendation here that's very explicit about what we want to look at and this is where the point in this chapter comes up. My sense was that we wanted to do more than just compare the two. We wanted to make comparisons where the comparisons were most relevant.

DR. WILENSKY: Do you have any language that would make you more comfortable?

DR. LAVE: Basically I would have focused on the payment amounts on those services where there is a significant overlap and where they're being provided.

DR. WILENSKY: Would you also think that having --

this would be where we could look both at what actually exists in terms of overlap and where clinicians advise future overlap is likely. We don't want to just look at where we've been.

DR. LAVE: No. But I wanted something in here so we wouldn't be looking at -- we focused last time on some major payment differences and it turned out that they weren't real because there was no overlap in where they were. It seems to me that we just want to take that knowledge and modify this a little bit.

MR. JOHNSON: This is probably a tangential question, but the beneficiary, what happens if you want to change the site of even something that's done a lot in the doctor's office because of the physical condition or other health problems of the beneficiary?

I mean, is that just the physician's choice? You do it in a hospital outpatient department so you'd have a crash cart, but you'd still get paid at the physician office level? I mean, how does this impact the beneficiary on site of care? All this is just talking about how we pay providers and how we incentivize them not to do the wrong

thing, which is not to charge too much.

DR. LAVE: My thing here was that I didn't want to -- I was actually being concerned about the beneficiary because I thought if we really brought the hospital outpatient departments significantly because they were so much lower, higher than the physician's office, that that could harm the beneficiaries. So I was thinking of this as much as the beneficiary protection as it was a hospital protection recommendation.

MR. JOHNSON: But I mean overall.

DR. NEWHOUSE: The question is if they get paid at the outpatient rate? The hospital would get paid the outpatient rate.

DR. CURRERI: And the physician gets paid at the same rate across boards unless there's practice experience involved and then an ambulatory service plan is deducted.

MR. JOHNSON: But there wouldn't be any prohibition against treating the beneficiary in a higher cost setting?

DR. NEWHOUSE: No. The first time prohibition surfaces here that I can think of is when we get to this

next chapter when we say shouldn't be done in the office.

DR. WILENSKY: Okay. Are we done with page 12? Any further comment? Page 14.

DR. KEMPER: I've just got two comments on this one. On the recommendation language itself, on the patient characteristics, I think it's important to make clear what kinds of patient characteristics, because you're not just talking about age, but you're also talking about gender, frailty, just to make clear what you mean by patient characteristics.

So patient characteristics such as, and give a couple of examples.

DR. CURRERI: Is this on page 14?

DR. KEMPER: That's where I am, in the actual recommendation. Because every time I see patient characteristics, I wonder what does that mean, age, gender. We're really talking about clinical. Maybe that's as simple as that.

The other comment I have has to do with facility-level adjustments, and I guess I didn't understand exactly what you intended here when you say facility-level

adjustment. Are you saying facility by facility, each facility would get a different rate, or urban facilities would get a different rate?

MR. MATHEWS: The BBA does make provision to adjust payments under the outpatient PPS for specific classes of facilities if warranted. The example that is in the legislation is cancer hospitals. They can have a separate conversion factor, which is attributable to the conditions of the patients that they treat.

We could think of other classes of hospitals that may or may not be eligible for special treatment. Again, due to the characteristics or homogeneity of the characteristics of the patients they treat, in that sense, we could say that all cancer hospitals are eligible for a certain adjustment or all rehab hospitals are eligible for a certain adjustment.

That's what I'm getting at, rather than a facility by facility.

DR. KEMPER: I guess it seems to me that it, in a way, undercuts the recommendation. It seems like it goes in the wrong direction. I'd be inclined to just cut that out,

but I'd be interested in the view of others, just take out the facility level.

MR. MATHEWS: The reason it's in there is sort of a hedge. We have no real, viable patient level adjuster now and given the kinds of differential impacts that we see, particularly in going to the outpatient PPS for certain classes of hospitals, some of them are taking tremendous, tremendous reductions in payments relative to prior law.

So we are just offering the possibility of some protection here.

DR. CURRERI: I also think there's a difference in case mix. I mean, picture something that's done 33 percent in doctors' offices, 33 percent in outpatient departments, and 33 percent ambulatory surgical centers.

My guess is there's going to be a stratification and the sickest, frailest patients with more chronic diseases are going to be in the outpatient department or the ambulatory care center, and the healthiest are going to be done in the office.

MR. MATHEWS: We have started looking at that and we have some preliminary results that are kind of

interesting where we look at a few benchmark procedures that are done in different settings and used the current Medicare beneficiary survey to make inferences about the characteristics of the beneficiaries.

We've looked at things like endoscopies that are done in both outpatient departments and ASCs. We've also looked at cataract surgery. We found or I have found so far -- I haven't presented this yet, but very, very few differences in the populations by age, by sex, by socioeconomic status who receive the care in these different facilities.

The only thing that comes out with any certainty is that the people who receive the services in hospital outpatient departments are much more likely to have more hospital outpatient visits and they're also more likely to have inpatient admission.

DR. CURRERI: Some of them may have coexisting diseases.

DR. ROWE: And they may be sicker.

MR. MATHEWS: Right. But that's the only thing that we've been able to isolate so far and it is a very

preliminary result, but we are continuing with that research.

DR. ROWE: Is this the same Medicare beneficiary file that some people were quadriplegic one year and not the next?

MR. MATHEWS: Right. So the next step in our analysis is to actually go to the claims for beneficiaries and look at the services that they actually received and start aggregating by beneficiary.

MR. JOHNSON: Just quickly in terms of an access issue. Would we be finding, let's say, in an urban, inner-city area where the only access is a hospital outpatient department? There aren't many free-standing physicians or anything else that people would tend to go to for the care to the outpatient department because there are no other ambulatory alternatives?

Most of the ASCs I'm aware of are located in pretty nice suburbs, for example.

MR. MATHEWS: That is possible, but we haven't really evaluated in detail access problems at that level yet.

DR. LONG: Maybe you could do some zip code comparisons.

MR. MATHEWS: We could.

[Laughter.]

DR. WILENSKY: Seriously, that was exactly my suggestion, is to look at it by zip code. Ted?

DR. LEWERS: Could I just ask Jim a question? Jim, when I read this originally, I looked at the word evaluate. I wasn't sure how far you wanted to go with that. Do you mean by evaluate, study it? What concerned me about this was your last sentence in this section, raise the possibility with some reservation, et cetera. I just wasn't clear what you wanted HCFA to do by evaluate. Is that the same as study or is it going a step further?

MR. MATHEWS: I interpreted your previous discussions to indicate that you wanted it to go further than simply study; that the goal of this Commission was to develop and implement a patient-level adjuster in ambulatory care. I can change the --

DR. LEWERS: If that's where we were, that's fine. Your language in the bottom just bothered me a little bit,

made me think about, do we know exactly where we're going to go with that.

DR. CURRERI: Is MedPAC going to do this or is HCFA going to do it?

DR. LEWERS: He's saying HCFA.

DR. CURRERI: I thought you just said MedPAC.

MR. MATHEWS: We are doing a smaller scale study where we're looking at a number of benchmark procedures. We don't have the resources to come up with a patient-level adjuster for all ambulatory care.

DR. LEWERS: HCFA doesn't either. But whatever the Commission thinks, I just, you know, you raised a red flag to me and I'm not sure what that meant. I perhaps would rather see the word study, if it is something that we have reservations about. That to me is very clear. Evaluate means you evaluate it and move on with it.

DR. WILENSKY: Is there any objection to the use of the term study rather than evaluate? Any further comment on this recommendation?

On page 14, the recommendation goes to the single sustainable growth rate -- page 15 -- with regard to all

ambulatory care services.

DR. CURRERI: I'd like to take out the words, from inpatient to ambulatory settings or, the last sentence. It just doesn't make any sense to me.

DR. ROWE: You want it to read --

DR. CURRERI: Migration of services among ambulatory settings as appropriate.

DR. WILENSKY: Not unduly restrict the migration of services.

DR. CURRERI: It shouldn't really have any effect on inpatient dollars.

DR. LAVE: But you wanted to -- but it seems to me that if, in fact, I have an SGR of 10 percent and I could, in fact, switch more inpatient services to the outpatient setting and that would push it up to 11 percent, I would want to, in fact, increase my SGR to reflect that.

I think that's what that point, in fact, is, knowing that the practice of medicine is changing, particularly -- take the bone marrow transplants. I mean, bone marrow transplants are now being shifted to a very low SGR. It could discourage some of that shifting.

DR. CURRERI: Yes. But again, you would do that in your next SGR. You want to have a floating SGR so wherever it floats to, you're going to approve that. I mean, if the SGR is going to work, it has to be a number that estimates what an appropriate growth is. If you're wrong one year, then you change it the next year.

DR. WILENSKY: But why don't you -- I'm not clear why you don't want to have basically as your principle, that you don't want to impede appropriate flow from inpatient to outpatient in setting it. It seems to me how you measure that --

DR. CURRERI: I couldn't agree more with you, but the SGR won't do that. The SGR, by nature, is going to restrict it unless you're going to retrospectively change the SGR after you find out that there's been movement.

DR. WILENSKY: Or it depends on whether or not, because of technological advances, you make an adjustment in an SGR to allow for growth because you expect to see migration.

DR. CURRERI: But that's a retrospective adjustment.

DR. NEWHOUSE: It depends on how binding it is. I mean, the higher the SGR, the less likely it is to restrict.

DR. CURRERI: That's right. I agree with you. I would agree with you on that.

DR. NEWHOUSE: I think that's the logic behind this.

MR. MATHEWS: I believe we can build a factor like that into the SGR that makes these allowances up front.

DR. CURRERI: You mean just artificially increase it for estimations of changes?

MR. MacBAIN: Site of service substitution.

DR. CURRERI: If the SGR is going to have any effect, it's going to have to be an estimate. It could be artificially high, but it can't be changed once you've made it. So that's the only point I'm making, that I'm not sure that it's practical, but maybe it is practical to be able to influence inpatient data.

MR. MacBAIN: It's not as good as incorporating everything under one SGR for inpatient.

DR. CURRERI: That's right.

MR. MacBAIN: I think that's probably a step too

far from where we are.

DR. KEMPER: I've thought a fair amount about this since our discussion last time and have some serious concerns about this recommendation. But let me first say the part that I agree with in the recommendation and that is the Middleson's that has to do with the update applying to all categories, outpatient departments, surgical centers, physician practices, and qualified health centers.

So the notion of having all the silos under one common update, I think, I support that notion. I think that makes a lot of sense. There are two concerns I have. One has been mentioned before in the discussion so far and last time as well and that is the site of care substitution, the movement from inpatient to outpatient, which is something that I think we'd like to see more of continue on efficiency grounds; that that, by definition, creates a need for a higher update and that we need to be much more explicit in saying that whatever is done needs to have that adjustment built into it.

That is that the update would be adjusted to account for migration from the inpatient to outpatient, and

I think the sentence there doesn't make that clear, the last sentence of the recommendation. It needs to be more explicit.

DR. NEWHOUSE: Do you have some suggested language?

DR. KEMPER: The language I would use is something like the update should be adjusted to account for shifts that occur from inpatient to outpatient care, outpatient broadly defined.

DR. NEWHOUSE: For anticipated shifts, to get to Bill's point.

DR. CURRERI: I could go along with that.

DR. KEMPER: And that would either be an addition at the end or replacement for that last sentence, and maybe the exact wording could be adjusted -- could be improved.

But more fundamentally, on reflection, I think a sustainable growth rate system is the wrong way to go with setting the cap, that we ought to adopt an approach more like the hospital update where there are judgments made about the appropriate level of update based on technological change, quality changes, and productivity changes over time.

Basically, the rationale is that the level of services that Medicare ought to be providing is not -- ought not to be driven by a formula that is a certain percent of GNP, but ought to be based on what kinds of services ought to be provided to beneficiaries.

So I would like to strike the use of the sustainable growth rate and replace that with an update as a matter of language to suggest it's not a formulaic approach related to GNP.

DR. LONG: Clarification on Peter's first point? I'm not sure I understand, Peter, why moving bone marrow transplants from inpatient to the outpatient department would require a higher SGR.

DR. KEMPER: Because that's something that's not a volume offset that's a result of payment changes within the outpatient ASC sector, the ambulatory care sector, but it's a beneficial exogenous, if you will, substitution into that

silo. It's a site of care substitution that increases, that leads to an increase in volume in that silo, but it's not a volume increase that's sort of an inflation.

MR. MATHEWS: It has a desired policy effect. Therefore it shouldn't be counted against the volume.

DR. KEMPER: That says it better.

DR. NEWHOUSE: Peter, I think the issue you're raising is what is the right mechanism of volume control, and it goes to what you were raising this morning about the difference between the two methods. I'm a little reluctant to take that on at this point in the day at this time of the year, although I think we could try to -- maybe we could try to be more neutral about it, but to say we're -- I mean, there is two legitimate competing philosophies here.

I mean, the SGR and the links to GDP or GDP-plus is basically an ability to pay philosophy. How much we spend ought to relate to what our total responses are, and the PPS philosophy, I think, is how much does it cost to provide this given benefit package that we have specified in law is a given benefit package.

Now, those are different and we are kind of are, if you will, at the collision of the tectonic plates here, but I don't know that we want to resolve that issue just over tipping this way or that way. Maybe we want to just

back off and be a little more neutral and say --

DR. KEMPER: I would much prefer being neutral about sustainable growth rate versus --

DR. NEWHOUSE: I think we ought to say, however, that if we go to SGR, that it ought to be the broad silo, the first point you made.

DR. KEMPER: If you deleted the first sentence, and maybe there would have to be some other language, but the second sentence says it's the broad --

DR. NEWHOUSE: Well, you can't have that because this sentence is an antecedent back to the first sentence.

MR. MATHEWS: Is it the term SGR that you're uncomfortable with?

DR. KEMPER: Yes. Well, it's not just the term.

DR. NEWHOUSE: It's the link to GDP.

DR. KEMPER: It's the link to GDP as opposed to link to benefits, and I would not want to make -- I'm perfectly comfortable with not making that decision in this recommendation. That would be just fine with me. What I don't want to do is just because of fatigue in the day and lateness of the year adopt sustainable growth rate. That's

what I mean.

DR. WILENSKY: Gerry, are you speaking to this issue?

MR. SHEA: Yes, and I can be brief, because I had the same -- my concern was the one that Peter raised last that we're now discussing, and precisely my thought here is can't we step back a step on this and not specify that the sustainable growth rate is the system that should be used to do this?

I'm just not at all convinced that this is the right formula in terms of beneficiaries' benefits here. I think it may be -- maybe we'll get there. Maybe it is the right thing, linking with GDP, but it seems like a blunt and convenient instrument to me that we could all regret down the road.

DR. WILENSKY: Is more general language of whatever volume constraints exist should be applied more broadly across the outpatient area?

DR. KEMPER: How about, HCFA should develop a system that would link updates to volume growth in all ambulatory care settings.

MR. SHEA: And together.

DR. KEMPER: And then the next sentence says that they're together.

DR. LAVE: Or in whatever system HCFA develops to limit overall growth, it ought to include all of these things.

DR. WILENSKY: Yes.

DR. LAVE: So that says, have a system, but one of the characteristics of that system should be the following.

DR. NEWHOUSE: But if you went to a PPS-type system, presumably that would be narrow. I mean, I'm not sure.

DR. KEMPER: No, that could be broad. That could encompass everything.

DR. NEWHOUSE: I don't know what that means. We could leave that for another day.

DR. CURRERI: If you went to a PPS system, I don't know that you could lump all of these together because these are dishomogeneous populations. It's not like hospital populations which are relatively homogeneous. Am I wrong about that?

DR. NEWHOUSE: I would have said you were just into kind of separate updates. I mean, you wouldn't presume that the same update that would apply to inpatient would apply to outpatient and you're kind of back to the silo. I mean, what is the cost of providing the outpatient benefit? Not all hospitals have outpatient departments or the mix of outpatient/inpatient differs.

DR. KEMPER: Well, it seems to me you're going to update a set of payment rates for a particular year and the question is, how big is that update and should it be similar across these various settings.

DR. NEWHOUSE: And the answer is, if there's migration from inpatient to outpatient, there probably shouldn't be. You'd have to adjust for that migration and that would get you into a separate update factor on the outpatient side.

DR. KEMPER: Not for the rates. The migration has to do with the volumes, not with the rates.

DR. NEWHOUSE: With the total pot. The total spending would have to be higher, you would want it to be higher, anyway, given the migration figure for payment.

DR. KEMPER: Right. But the whole pot could be bigger for all the ambulatory settings.

DR. NEWHOUSE: Well, if they're just migrating, particularly if you're saving money from the migration, the whole pot shouldn't be bigger.

DR. KEMPER: No, the whole ambulatory pot, the broad silo for the ambulatory.

DR. LONG: But would that imply that the migration was homogeneous to all outpatient settings?

DR. NEWHOUSE: Then what you've done -- then we're back off the SGR for physician services, which may be a position that we want to come to, but we probably couldn't come to it at this hour of the day at this time of the year.

DR. KEMPER: I agree.

DR. LONG: Did BBA specify a time by which HCFA is supposed to implement a volume control mechanism?

MR. MATHEWS: It appears in the same language with the outpatient PPS and the presumption is that it would be implemented concomitantly with it.

DR. WILENSKY: I didn't hear the answer to that, sorry.

MR. MATHEWS: I believe the presumption or the intent of the legislation is that the volume control would be implemented simultaneous with the outpatient PPS.

DR. WILENSKY: I don't know whether Judy's alternative language will help us for the moment. We started this discussion last summer in terms of the different mechanisms for building up or starting from a global number and pushing it down, and I don't think we're going to be able to resolve that today and tomorrow for the March report.

The question is whether we can come up with wording which adequately indicates our interest in taking a broader rather than a narrower look at spending growth in ambulatory settings, and I don't know whether the language that was suggested would allow us to do that without imprisoning us in concepts that we may wish to disassociate ourselves from.

I don't know whether you can show us what Judy's language looks like to see whether that would make us --

DR. ROSS: Judy's language was pretty broad.

DR. LAVE: I said whatever approach it would take

to develop --

MR. MATHEWS: I think I can do what you want.

DR. KEMPER: When we see it, we might not want it.

DR. NEWHOUSE: What if we framed it negatively? What if we said, if HCFA were to adopt an SGR system, it should be broad?

DR. WILENSKY: Actually, I thought -- I liked Judy's language.

DR. NEWHOUSE: I'm sorry. For hospital outpatient.

DR. WILENSKY: I think I like Judy's phrase best.

DR. KEMPER: I like Judy's way of punting is better than that.

MR. MATHEWS: I'll see if I can play around with that and get it back to you.

DR. LAVE: It probably wouldn't pass the Microsoft Word grammar check.

DR. LEWERS: I was just waiting because I wasn't sure what you were going to do with Peter's, because one of the things that I was concerned about, I had read HCFA's comments on this and this sort of whole process puts a 17

percent reduction on rural hospitals, almost 30 percent on cancer hospitals, and I was wondering if we could fall back to where we had before and that's recommending a phase-in. They even speak of a phase-in may be appropriate.

I don't know where to put it. I was going to try to stick it in here where you develop and implement through a phase-in program or something of that nature, and if you're going to be playing, play with that.

MR. MATHEWS: Right. Another thing that I kind of thought of sort of very late in the game would be a hold harmless implementation where you've got a corridor of 10 percent loss or a gain for the first year or two. It would also achieve the same kind of protection that a phase-in would, but I wasn't sure about whether we had a vehicle for getting such recommendations into this report, but it's your call.

DR. LEWERS: Phase-in is a kinder word than hold harmless these days, so I would recommend phase-in.

DR. NEWHOUSE: And also, a minus 10 percent is not exactly consistent with hold harmless.

DR. LEWERS: Yes. Before you leave that, also,

just above this on the top of page 15, there's a comment, volume growth partly results from growth in Medicare fee-for-service population. In other areas, we talk about the fee-for-service population decreasing. I think the figure was 4 percent, and so here, we're talking about it growing and that's the reason. So I think we need to be consistent.

MR. MATHEWS: I can say, volume has historically grown, something like that.

DR. LEWERS: Well, that sounds like that's what's going to happen in the future when we at least have recommendations elsewhere that's not.

DR. LONG: Why don't we just talk in terms of changes to encompass both directions?

MR. MATHEWS: Okay.

If I can get a clarification from Ted. When you talked about the phase-in, was it for the particularly vulnerable classes of hospitals or were you speaking of a general phase-in?

DR. LEWERS: No, I'm talking about -- at least there appears to be from what HCFA had said a number of individuals who are going to have rather significant swings

immediately --

MR. MATHEWS: Right, that was the rural hospitals.

DR. LEWERS: -- with PPS, et cetera, and I'm thinking about the whole structure ought to be phased in rather than just the sustainable growth.

MR. MATHEWS: Right, but my question --

DR. LEWERS: I don't know where to put it.

MR. MATHEWS: My question is, would the phase-in apply only to those hospitals that HCFA identified and that we confirmed or would the phase-in apply for all hospitals?

DR. LAVE: I think it has to apply to everybody the same way we've done. I mean, how they would do it you'd have to think through, but wouldn't you have to do it for everybody? That's what we're doing with the blending and the hospital PPS.

DR. LEWERS: I hadn't thought about it in that context, but my first blush is that it would have to be everybody.

DR. NEWHOUSE: And it would have to restrict presumably the upside to it.

DR. LEWERS: Right, I would think it would. While

you're playing, think about that one.

MR. MATHEWS: I would do this with some trepidation, though. One of the huge pitfalls in the history of the development of the outpatient PPS was a proposed phase-in of the system where HCFA was going to implement it first for surgery. Then they decided that they had sufficient data to also bring in radiology and other diagnostic procedures, leaving the whole E&M, therapy, other services still under a lesser of cost charge or based reimbursement. So I think we would very strongly want to avoid that situation where you've got --

DR. LEWERS: My major concern was looking at the rural hospitals who were going to drop down, looking at cancer hospitals that were going to drop 30 percent by their projection.

DR. WILENSKY: You're suggesting more a phase-in with regard to a blend issue to soften the blow as opposed to a staged introduction?

DR. LEWERS: Right. I guess that's yes, blending, I guess.

DR. ROWE: Those kinds of dramatic reductions in

the cancer hospitals might get them like the rest of us or something like that. We don't want to do that too quickly.

DR. LEWERS: Don't want to get too close.

DR. NEWHOUSE: This goes to the facility adjuster. Maybe there should be a separate rural rate or a separate cancer rate, which would -- I mean, that would be an alternative way to address the problem.

DR. LEWERS: Since we're doing broad things today, maybe we could just try to work in something to soften that blow.

DR. LAVE: We could say that we've very concerned about the impact on selected types of facilities.

DR. WILENSKY: Bill, did you want to continue this discussion?

MR. MacBAIN: Yes, let me jump in on this.

DR. LEWERS: Excuse me. Can I just read this? This is from the Federal Register. One option would be to phase in the outpatient PPS for a low volume, Medicare-dependent, or sole community hospitals, et cetera. That's sort of the element that I was thinking about and adding cancer, which is being hit hard.

MR. MacBAIN: Fortunately, Jack is looking out for cancer hospitals.

DR. ROWE: The answer that I got when I asked here a year-and-a-half ago, why do these guys have such a different deal than everybody else and it was, quote, they're politically influential. I mean, that was the answer I was given.

DR. LEWERS: We're trying to be political.

DR. ROWE: If that's what we want to protect, let's protect it, but that's not what I thought we were trying to do.

MR. MacBAIN: By and large, the rurals are not. What really concerns me is not just the hit on the outpatient revenues, but the fact that a lot of these hospitals are heavily dependent on their Medicare outpatient revenues, so it's going to have a hit on their bottom line and then it's coming hard on the heels of another hit coming through their SNF revenues, which also, in many of these cases, is significant.

I think we're going to have a number of sole community, rural hospitals in real trouble when all this

stuff filters its way through unless we build some kind of a net under it.

Because it cuts -- at least in my mind, it cuts across these specific elements that we keep looking at, it doesn't fit in the outpatient chapter or in the SNF chapter, but somewhere there's got to be room to take a horizontal look at vulnerable hospitals and say, what are we doing when we stack all these things together and is there a class of hospitals that deserves or requires some additional protection because of their overall role in the community.

DR. WILENSKY: Before we can make -- it's one thing to make a statement that says we should assess to see whether or not the combination of policies particularly affects or injures sole communities or a broad class of hospitals, I have no difficulty with that statement.

To assume that there is this combined effect without actually being able to have assessed the effect strikes me as inappropriate for the conclusions here.

MR. MacBAIN: That's fine. But my concern is without looking at it. We don't know the answer to that.

DR. WILENSKY: Again, if you can add a statement

to reflect that?

DR. ROWE: I think on the issue of the cancer and pediatric hospitals that we discussed before, I have a pediatric hospital. They're no different. I mean, they're just not different and I think that the key here, if we're going to be fair about it, is what Bill MacBain said and that is a broad class of hospitals.

If we're talking about a broad class of hospitals, that's one thing. If we're talking about a politically operative group of nine hospitals, you know, that have gotten together around the country or something, that's not a broad class of hospitals. So we should just be honest about what we're talking about.

My other comment has to really do with what Gerry said early on. We're getting into the latter parts of the work where I think Gerry was saying that there was a lot of kind of wimpy language and maybe we shouldn't or, if we can't do it, it's okay, or it's impossible.

Now we even have a recommendation that begins with the subjunctive. That was my threshold. If in the unlikely case that --

[Laughter.]

DR. ROWE: The subjunctive was my threshold. I think that we should -- whoever reads these recommendations before, whether that's Murray or Stu or whoever, before they get typed up on a few papers and sent to us, I think it should be a little more auditory, a little more imperative to them because we've spent a lot of hard work on this and we're too politically correct and too polite here and we're not going to get anybody's attention.

DR. ROSS: We'll certainly do that on the GME report.

[Laughter.]

DR. ROWE: My strategy was that we were never going to get to the GME.

DR. WILENSKY: Okay. Move beyond page 15. The next recommendation is at the bottom of page 16, not using patient diagnosis.

DR. NEWHOUSE: HCFA wanted to use patient diagnosis. We didn't want to.

DR. WILENSKY: This is the use of a HCPC rather than the patient diagnosis.

DR. NEWHOUSE: HCFA wanted to do both.

DR. WILENSKY: Okay, but the recommendation says should not, right, should only use the HCPC and not patient diagnosis to calculate the relative weights. Peter?

DR. KEMPER: I agree with the recommendation. I thought the rationale probably could be strengthened a little bit. It didn't persuade me and I think some of the material you had here before was probably a little stronger making the case.

DR. NEWHOUSE: Other views on this?

DR. LEWERS: Just quickly. You're missing a word on the second sentence between needed and differentiate. I think you need to or something in there. Just a simple editorial thing. Something's not right.

DR. LAVE: I guess my concern on this was one on whether or not -- which I brought up a little bit -- we are recommending on the service and for evaluation and management, I guess we're arguing that we don't think we have enough information to do episodes of care-type analysis. We can really use can we do episodes of care.

If you did episodes of care, then you'd want to

have diagnostic information. So at this point --

DR. NEWHOUSE: Are you looking toward building a future episode system?

DR. LAVE: Well, I basically am saying that -- that's why I was trying to figure out why HCFA had done it. That's why I asked the question.

DR. NEWHOUSE: I see. Was there a hidden agenda?

DR. LAVE: And I was told there is a hidden agenda. That means that, in fact, that HCFA wanted to move to more episodes of care, but I would think that at the moment that until it has the methodology to build the episodes of care, it may as well start with the HCPC code.

DR. NEWHOUSE: Doesn't it have to confront then the problem that the diagnosis code is historically incomplete?

DR. LAVE: That's true.

MR. MATHEWS: But this doesn't preclude HCFA from issuing guidelines or regs.

DR. NEWHOUSE: That's just collecting the data. It just says don't pay on it.

DR. LAVE: And I think we may want to say that we

wouldn't move in that direction, but at this point, we shouldn't use it in the setting of payment.

DR. NEWHOUSE: That should be in the text, I would think.

DR. WILENSKY: Right, that's a text addition.

DR. NEWHOUSE: Other issues? Okay.

DR. WILENSKY: The bottom of page 17.

DR. NEWHOUSE: This sort of goes to Bill MacBain's concerns.

DR. WILENSKY: This is a closely monitored.

DR. NEWHOUSE: Is this adequate for your concern about the horizontal path?

MR. MacBAIN: My main concern was adding this together.

DR. NEWHOUSE: So it's really more than just monitoring hospital outpatients.

MR. MacBAIN: This gets added in. You can all see it by itself and say that looks okay, but when we add them up horizontally, you realize you've got to balance the hospitals.

DR. WILENSKY: Page 18 at the bottom. Is there

any additional comment beyond what we've discussed? Okay.

On page 20? This has to do with the beneficiary coinsurance buy-down that we have discussed.

DR. ROWE: We talked about just changing it to the recommendation that was on the overhead as opposed to --

DR. WILENSKY: Right, to add that it should not come out of the hospitals.

DR. ROWE: That thing in the lower, the next to the last paragraph there. We're going to add that to the recommendation, right, Jim?

MR. MATHEWS: That's correct

DR. WILENSKY: Page 21?

DR. ROWE: When we say HCFA should carefully monitor, that means as opposed to not monitor?

DR. LAVE: We might have a recommendation that says HCFA should get more money to do all these things that we've told them to do.

DR. LEWERS: We did that somewhere.

DR. WILENSKY: Any final comments on this?

DR. ROWE: In the unlikely event that HCFA carefully monitors --

DR. LAVE: I think we ought to give a round of applause for having struggled through all of this.

[Applause.]

DR. NEWHOUSE: No longer the anvil.

MR. MATHEWS: I'm doing dual eligibles next here.

DR. WILENSKY: Are there any public comments on the outpatient?

MS. FISHER: I'm nervous a little bit when I look at the clock and see that it's 5:25. I'm Karen Fisher from the Association of American Medical Colleges and I would join in the round of applause for Jim Mathews, but I would like to point out one clarification maybe.

That is related to the phase-in, and Jim had pointed out that there was a problem with the stalling almost in HCFA's original plan of how they would move to a sort of prospective payment system, which they started with surgeries and moved to a blend and then they added radiology and then it got stalled.

So that E&M visits, that never happened and that's a problem. I don't think if you'd implement a phase-in under a PPS system you'd have that problem. Once you

develop the methodology, you would sort of have it lock-step. That methodology would occur 20 percent, 40 percent if you had a five-year phase-in.

So I think that you have to look at it that way and once the methodology is established, it would just occur lock-step, and when you think about major changes that have occurred in the Medicare program and prospective payment, the PPS system itself, capital, the managed care carve-outs, and the BBA, many of those major policy changes have occurred with a phase-in.

When we look at how big a change this is going to be, I think a phase-in is something that should be seriously considered. Thank you.

DR. WILENSKY: Carmela?

MS. COYLE: I wish there was someone here from the cancer hospitals who could do this more eloquently than I can, but I did raise a adjust issue that Jack was raising. There is a significant data problem in terms of the data around cancer hospitals, basically chemotherapy and some of the drug codes that were used that has resulted in some of the problems around including them in the outpatient PPS

system.

Some of it has to do with the translation of CPT codes to HCPC codes. I think an easy example to illustrate the problem, CPT codes, the ones hospitals use in this case, classify chemotherapy in 30-minute increments. But if you had a two-hour session, it's four 30-minute increments, but in the HCPC codes, it would count as four visits rather than one visit.

So there are some real data problems here that are just significant bad data when it comes to the cancer hospitals. The bottom line in all of this, we would recommend exemption exclusion of both cancer hospitals and rehabilitation hospitals and a phase-in of sole community providers who could have adverse impact. I think that was going to Dr. Lewers' point. Thanks.

MR. SHEA: Carmela, but not a phase-in for anyone else?

MS. COYLE: Exclusion for cancers and exclusion -- this is for the outpatient people.

MR. SHEA: But you wouldn't support a general phase-in, is my question?

MS. COYLE: No, in terms of year 2000. We're looking for sole community provider phase-in there.

DR. ROWE: The data being collected at the cancer hospitals is different than the data being collected for cancer patients than the non-cancer hospitals?

MS. COYLE: No. All the chemotherapy data was problematic, but because they are hit disproportionately in terms of the usefulness of that data to describe what they do primarily within cancer hospitals makes the impact particularly bad for them.

I should turn to my colleague here, where's Deb? She's much better at this than I am. I wish we had a few more minutes to get our comments together and I could be more eloquent here.

Problems not only with the coding of chemotherapy, but also with the drug codes in general and the use of multiples. Deb, do you want to talk more about that?

MS. WILLIAMS: The exclusion of multiples, which is how the --

DR. NEWHOUSE: Why don't you go to the mike?

MS. WILLIAMS: The J codes -- the issue simply

here is, is that J codes describe drugs in units that aren't actually the ones that are marketed and used by hospitals, which leads to hospitals sometimes, for example, the J code says 300 milliliters. They use 50, so what you'll see is a J code that the hospital might have pro-rated their charge, but HCFA doesn't know that. That's the problem with drug codes.

The problem with multiples is that chemotherapy is almost always multiple sessions. All the multiple sessions were thrown out of the data because of the problem of the fact you couldn't untangle the cost per unit. So what the oncologists are saying is they don't know whose left in the data because they don't know who is it that gets single chemotherapy sessions. It's very unusual.

DR. ROWE: Is it clear that it's disadvantageous to them or it might even be advantageous to them that the data is bad?

MS. WILLIAMS: Obviously, since the cancer hospitals lose 30 percent, I think it's very disadvantageous, and we've looked at, for example, the by drugs and we're just arraying AWP within the chemotherapy

agent groups and very funny things happy there and those funny things -- there's nothing intrinsically wrong with grouping, mind you, like for drugs.

The problem is is they're getting very expensive drugs stuck in some very low-cost groups, which I think point to real significant data problems. And all because you have expensive drugs in low-paid groups, it creates huge losses.

Theoretically, chemotherapy should be no worse off than anybody else, but due to these profound coding and data problems, it's a real problem.

DR. LEWERS: Jack, there are a number of very technical issues relating to oncology which are trying to be worked out that are creating the problems that they're speaking of. I mean, even the access device that they use, how that's coded is another problem. So all this is trying to be worked out, but we haven't included it.

DR. WILENSKY: One possibility we could consider is to suggest a short, specific exemption like a two-year exemption. I'm very uneasy about any notion of indefinite exemptions, but I don't know --

DR. LEWERS: Or particular attention to the problems.

DR. ROWE: You know, the phase-in approach includes them, like all other hospitals, in the category of having this happen to them, rather than giving them an exemption where they're exempt and then we have to remember to come back several years later to put them back in and then there will be another reason why. So the phase-in would soften the blow of these inadequate data if, in fact, they're disadvantageous.

DR. NEWHOUSE: If the problem gets fixed.

DR. ROWE: That would certainly provide an incentive to get the data problem fixed.

DR. WILENSKY: A phase-in and a blend definitely softens the hit. So to the extent that we recommend a phase-in and a blend, that will do it.

DR. ROWE: I mean, I don't have any a priori -- I don't have anything against cancer hospitals. I find these considerations much more valid than the previous considerations that we were given as reasons.

DR. WILENSKY: I agree.

MR. CALLEN: Mark Callen, Health Care Association of New York State. I would like to say that we also support a phase-in across the board, but I'd like to talk a little bit about why.

I don't think that the problem with data is solely related to the cancer hospitals. I think that the '96 database, the claims file that was used, is a problem that HCFA has had to work very hard to overcome, because the coding that is in that file is not a coding that is oriented towards a PPS system.

The coding was in place basically for a cost-based system. Inaccurate coding did not cause you to lose your reimbursement; whereas, under a PPS system, the coding is extremely important that it be accurate.

So HCFA itself had to weed out a substantial number of the claims in the database in order to come up with the relative weights. We've looked at -- we've analyzed the full database ourselves and we just are totally uncertain as to how realistic the major losses or gains for certain hospitals actually will be when they actually go on the PPS and actually have to do more accurate coding.

I think that with this level of uncertainty, that it would be totally inappropriate to, in year one, put everybody on the PPS when I think we're going to find that some of the problems will go away, but some of the problems will not go away, and by phasing it in, we may be able to catch the problems and make adjustments before hospitals are hurt too badly.

DR. WILENSKY: Julian?

MR. PETTENGILL: Could I just remind everybody that quite a long time ago when we put PPS in place, we had similar coding problems, lots of them, and when the system was put in place, the actuaries tried their best to make it budget-neutral to what they anticipated spending would have been.

But it turned out to be a lot higher. The reason it turned out to be a lot higher, I think, is that the hospitals recognized what they were going into, they knew how they had to change their coding to get paid fairly, and they did it.

So you have to wonder about these estimates. Is 30 percent real? Is that what will actually happen? I

think there's tremendous uncertainty about that.

DR. NEWHOUSE: But isn't that another reason to phase in?

MR. PETTENGILL: I think it may well be a good argument for phase-in.

DR. NEWHOUSE: If we'd have gone -- to take the PPS example, we've got 100 percent PPS immediately, we would be taking the full amount of the hit.

MR. PETTENGILL: You'd have taken the full hit, that's right. On the other hand, you kind of have to think about how you would do it.

DR. LAVE: That was what I was going to say. I think that it might be interesting to make a recommendation that HCFA spend some time on working on a phase-in system.

DR. ROWE: Subjunctive.

DR. LAVE: Subjunctive. That we would recommend that the system be phased in. Maybe that's what we should say and then basically let them say they can't do it.

DR. WILENSKY: We have basically recommended phase-in any time we think there's a significant impact for a provider group.

DR. ROWE: Or HCFA. I mean, I think that there's a risk on the other side of paying too much.

DR. LAVE: So I think we should make a recommendation.

DR. WILENSKY: It is late but we are going to continue on because I am afraid otherwise we will not get done by mid-afternoon tomorrow. So Kevin, physician services and the recommendations.

DR. KEMPER: Could I suggest we go recommendation by recommendation rather than going through twice?

DR. WILENSKY: That's fine. Kevin, is that all right to proceed that way?

MR. HAYES: Yes, I was going to suggest the same thing, so that's good. So we have nine recommendations to go over here and we have overheads that summarize them, so we'll just go through them one at a time.

I'd just point out on the front end here that we have recommendations that address three general issues with respect to physician services. First would be making the transition to resource-based practice expense, RVUs; second, developing professional liability insurance expense, RVUs;

and finally, improving the sustainable growth rate system.

In the area of practice expense, we have two recommendations having to do with what's known as the site of service differential. This differential reduces practice expense payments for services provided outside of physicians' offices in facility settings such as hospital outpatient departments and ambulatory surgical centers.

The first recommendation that we see here is in two parts. It says first that HCFA should determine whether a clinical consensus exists about the appropriate settings in which services should be provided, and then it goes on to say for services which should not be provided in the physicians' offices, HCFA should set both the office and facility practice expense RVUs at the lower facility practice expense RVU level. So we want to talk about this? We'll just go through these one at a time.

DR. NEWHOUSE: Right, seriatim. Any issues here? Everybody's comfortable?

DR. LEWERS: That's the one on page six?

DR. WILENSKY: Yes.

DR. LEWERS: I just have one suggestion. On the

middle of page seven, we talk about, it says any interim monitoring of changes in beneficiary use services by site will be necessary. I think that ought to be part of our recommendation, that there be a monitoring, that we could just move that language. I don't think you use it in any interim or anything, but just put some monitoring element in there. I think that's significant, you know, by site of service.

DR. NEWHOUSE: Problem with that? Bill, is this a problem or a new point?

DR. CURRERI: It's on this recommendation.

DR. NEWHOUSE: I understand. So we've agreed to Ted's modification? Okay.

MR. HAYES: I'm sorry. Could I just get a little bit of clarification here? In the text, we talked about this being a Commission activity, really, to do this kind of monitoring. If we move it up into the recommendation, then we're suggesting --

DR. ROWE: We don't have to recommend to ourselves.

DR. LEWERS: That's a recommendation to ourselves

only?

DR. NEWHOUSE: It says MedPAC intends to integrate.

DR. LEWERS: It says Commission believes, but then it goes on, monitoring, and I wasn't sure. If that's what you want, then I don't need to add that because we can do that, so that's fine.

DR. CURRERI: I have a little problem with the finality of the recommendation, and I wonder if we couldn't put some time limit or say during refinement, HCFA should determine at frequent intervals or annually or every five years or something, because these things change.

DR. NEWHOUSE: Yes, that was my trouble with this whole thing.

DR. CURRERI: And what isn't practical to do in an office today may very well be practical two years from now. You might just want to say --

DR. LEWERS: Periodically.

DR. CURRERI: -- appropriate intervals or something like that.

MR. HAYES: One way to handle this would be that

HCFA is required to go through something like a five-year review of the practice expense RVUs is necessary just as it is for the work RVUs in the fee schedule. So one way to address these issues would be through that five-year review process.

DR. NEWHOUSE: You say that's in the law now?

MR. HAYES: Yes. They have to go through a five-year review of all RVUs in the fee schedule.

DR. CURRERI: I think that's too long.

DR. MYERS: Can we give ourselves the ability to make a shorter interval for the recommendation? Maybe make a declarative statement. MedPAC will monitor and will recommend an interval after we have some initial experience.

DR. NEWHOUSE: The interval here is whether the list should change or how frequently one should review to see if the list should change for services that might migrate to outpatient, and I don't think we can -- I mean, this is basically a clinical advisory panel.

DR. MYERS: The issue is the length of time. That's what we're trying to address, correct?

DR. CURRERI: I would be happy even if we said

something, at appropriate intervals, or something like that that leaves it up to HCFA to define what they are.

DR. NEWHOUSE: I guess, Woody, should we be more repetitive?

DR. MYERS: Should we reserve for ourselves the right to recommend a shorter than five-year interval?

DR. NEWHOUSE: Not let HCFA decide? If HCFA turned around and said five years is appropriate, that's what we're doing, would we be happy?

DR. CURRERI: No.

DR. NEWHOUSE: So should we specify a time?

DR. MYERS: That's exactly right.

DR. CURRERI: We might say, at least at three-year intervals or something like that.

DR. NEWHOUSE: Is that it?

DR. MYERS: I'm trying to help Bill in the sense of -- if you say appropriate, then that's somebody else's definition for appropriate. I would say we should determine what's appropriate, i.e., the length of time, perhaps after there's been some initial experience with it.

DR. NEWHOUSE: I don't think the initial

experience is it. It's how fast medical technology moves and it's going to keep moving, presumably.

DR. MYERS: Then I would say at least every two years.

DR. CURRERI: I think that's fair.

DR. NEWHOUSE: Any objection to that?

DR. KEMPER: During refinement and at least every two years subsequent.

DR. LEWERS: This is just for this element?

DR. NEWHOUSE: Yes. Page seven at the bottom, site of service on a service-by-service basis.

MR. HAYES: Right. Discussion in HCFA's final rule on the fee schedule for 1999 suggests that this issue of site of service differential could be considered with respect to broad categories of services, and as you can see in the paper we sent out, it looks like there is some variation within these broad categories of services about the extent to which services are provided in different settings.

DR. NEWHOUSE: Okay, that's fine. Let's go on to page eight. Participants is misspelled.

MR. HAYES: Sorry. This recommendation is really a summary of a point we made in a recent comment letter we submitted to HCFA about the process that they go through for refinement, and we recognize the different levels of expertise, different areas of expertise required for refinement, and just wanted to capture that in a recommendation.

DR. NEWHOUSE: It would stay consistent with ourselves. So page nine, seeking advice from the Advisory Committee on Practice Expense Refinement. This was also in the comment letter?

MR. HAYES: Yes, sir, it was.

DR. LEWERS: I'm just wondering why we want an additional bureaucratic area to do this. You know, that's basically what the RUC is and if you look at the top of page ten, it's establishment would create a forum and a structured process for consideration of any refinement.

That's what the RUC is, that's what the PEAC is going to be, and I think some of that is our job. I just don't think we should recommend another advisory committee and the expense of doing it. I don't see where that adds

anything at this point.

DR. CURRERI: I have a real problem with that, too, because the advisory committee is likely to be the physicians for the carriers, like it has been before, and I don't think you get very broad input there.

To me, it's just adding another administrative delay.

DR. LEWERS: In addition, we talk about the PPAC, the practicing physicians. That had a tough time getting going and it took the will of several people to even make it meaningful. It still has some problems. It would be the same thing all over again. I don't see any reason for another group to do this.

DR. NEWHOUSE: You would pull out this recommendation and the supporting text?

DR. LEWERS: I would pull the recommendation out.

DR. NEWHOUSE: Anybody want to push to keep it?

DR. CURRERI: I think there should be a positive statement. I would prefer saying that HCFA should seek advice from this formal process that they've been using before, namely the RUC and PEAC.

DR. NEWHOUSE: I would have thought -- this thing about practice expense refinement, this is the PEAC, but that's what the PEAC is about in the first place, right? I mean, that's their whole raison d'etre, if I understand it right. So we don't need to say the PEAC is supposed to concern itself with practice expense refinement. That's what they're supposed to be doing.

DR. LEWERS: That's what they do. I mean, I don't mind seek advice or continued advice or something in the refinement issues. That certainly is something that we need to keep track of, and I think we may actually end up involved in that process, at least in reviewing what's done. I just don't think there should be a new, you know, advisory committee.

DR. NEWHOUSE: I can't see making a recommendation that says the PEAC should review it.

DR. LEWERS: I don't either. I'm happy with taking it out.

DR. NEWHOUSE: Okay, let's take it out. Page 11. This is the risk of service for PLI. Ted, do you want to talk about the data you showed me?

DR. LEWERS: I have quite a bit of concern about this. I'm actually concerned to the point that I went and got Joe's original paper. Well, I guess it's Brennan's original paper.

DR. NEWHOUSE: Well, I don't want to disclaim responsibility.

DR. LEWERS: I have got data here and you can pass it around if you want to take some of it. I have no objection to them looking, and I hope they are looking. I would think that's part of the process of looking at alternate methods.

I just don't think that the risk of service is necessarily the way we need to go. It might be one of the ways we need to go. They've only got five months, supposedly, before they report, but the study that was done that Joe participated in was at, I guess, Boston, I assume several hospitals, but times have changed.

That data is old data. It's a small study. The authors themselves indicate that it's a small study, and things have changed in the liability world. If you take a look today, and I have the paperwork passing around is from

the PIAA data-sharing system which has been going on for several years and it's as of October of '98.

If you look at the ten top prevalent procedures, six of those are non-invasive. If you look at the most extensive procedures, five of the top ten are non-invasive. The most common cause for claims today are failure to diagnose.

I just don't think that this system picks that up and I think we've come down too hard on saying that that is the system they need to look at. I think if you want a recommendation which says that they look at alternative systems through the changing structures that have been going on, fine.

But I just don't want to bring in, as the sole one, the risk of service.

DR. NEWHOUSE: Let me make two responses to that. One is, the intent of the old study was to try to provoke somebody to do what you just did, although you didn't call it a study, but to basically get some better data and to endorse the general principle that the PLI adjuster ought to be based, I think ideally, if you had enough data on the

risk of pay-out, but if you didn't have that, and you might well not because it's small numbers and skewness then the risk of a claim and the notion that a claim imposed expense on a physician so maybe they were responding to that.

So either way, I could live with that, but I think the general principle that you ought to differentiate which services are generating claims for pay-outs and which services are not, they ought to be accounted for in the adjuster. I think that's the general principle and I think that's actually what the recommendation says.

Now, where these data -- these data need to be augmented. They need to be augmented by what I would call this is the numerator. What we need in addition to this is the frequency with which the procedure or service is done, because even though there's 3,500 brain-damaged infants and 2,200 --

DR. LEWERS: That's files reported. That's not necessarily the data.

DR. NEWHOUSE: But basically the spirit of it, it's the numerator of how many claims or potential claims, and for the adjuster, you need some kind of -- like the

probability of a claim given the service. Since you're paying on the service, then you want to basically add the extra payment to the services that are more likely to have a claim. You understand what I'm saying?

So what we need is to augment this with some kind of, what was the --

DR. CURRERI: You've got to have a frequency per service.

DR. NEWHOUSE: Yes, a frequency of the service. Then I'm with you. And I'm not fighting you at all about the distribution has changed and there's more failure to diagnose.

DR. LEWERS: I understand that. But you've got to understand that in the liability world, you have a number of cases that are riskier. They're riskier in the most cases because the patients that are involved in that are riskier, but it doesn't cross the whole line.

I can show you data upon data of a single -- take the one that's in here. There's one that's fairly high, spine surgery is one of the ones that fall out on the top. But I can show you spine surgeons who have never had suits.

They do the same procedure over and over and if you look at a lot of this, and this is where we work in our risk management program, a lot of it purely falls down the documentation and communication on the part of the physician.

So you have a lot of variables. It's not just the procedure and that data is not available. This is as close as you can come to say these are the procedures that are occurring. But if you take a look at the spine, you've got 5,318 cases; 4,757 have been closed, but only 1,500 of those were paid.

The others of them were basically not part of the process, and you've got riskier procedures. So I just -- I have no problems with an alternative method being evaluated, but it's going to take a lot of work to be able to do it and to be able to collect the data. I don't know how you're going to pull all that data together in the short period of time that you've got.

DR. NEWHOUSE: Now you know why we did this small scale study.

DR. LEWERS: I understand that. But what I'm

simply saying is that we've got to change this recommendation to say that there should be some looking at alternative methods, but I thought that's what they were supposed to be doing in the first place.

To set up the practice expense, they've got to figure out some way of doing it.

DR. NEWHOUSE: But they basically haven't done it. They've basically -- all they adjust for is specialty, basically, within specialty. If a surgeon does invasive stuff and non-invasive stuff and if it were the case that the invasive stuff generated more claims or more pay-outs, there's no account taken of that.

That was really the point here. Or if there's more failure to diagnose in one kind of diagnosis, one kind of code than another. The problem is that's going to be hard to -- see, that will probably all turn up in an E&M code.

DR. LEWERS: Well, it's breast cancer and it's colon cancer.

DR. NEWHOUSE: Yes, but it's not clear that the E&M codes differ for the cancers as it's been for any other,

so that would get -- because basically it's like practice expense. At the end of the day, you have to take this all back down to the code level.

It's wildly improbable to me that the risk -- I think the risk of a claim is very different across different codes. I mean, it's just improbable that there's not much variation.

DR. LEWERS: Well, you see the difference here and that's different codes, too. I don't know how to word the recommendation.

DR. MYERS: Are you saying, Ted, to use ROS now, then quickly develop something better, or are you saying not to use ROS?

DR. LEWERS: I don't think you can use risk of service, per se, as -- I mean, if you're looking at service as OB delivery, Cesarian section, non-Cesarian section, or you're looking at spine surgery or you're looking at colonoscopy with or without biopsy, to go through all of those codes and say here is a risk factor, that data is not available. The closest thing we've got is what I've circulated to you and I don't know that you could pull this

out to do it.

DR. NEWHOUSE: I agree with you, Ted, but you can say the same thing about practice expense generally. I would have said it's even worse for practice expense.

DR. CURRERI: I think actually the recommendation is okay, Ted, because it says should consider the ROS method for development. It doesn't say they have to do it, but that's a future goal. I firmly believe that there is a different risk across different codes, and if you don't put that in, it's no more resource than man in the moon.

DR. NEWHOUSE: That was really what I thought the recommendation -- the point the recommendation was trying to make, but if you're saying, Ted, well, we don't think you can ever get there, then if we buy that, I don't happen to, but if most people do, then I think it's incumbent on us to say what we think they should do in the PLI adjuster.

DR. LEWERS: If you wanted to say that HCFA should consider alternative methods for the development of PLI expense RVUs such as risk of service, I would have no problem. It appears to me we've isolated it out and I think there are other areas that we could look at.

DR. NEWHOUSE: I was like Bill Curreri. I was taking risk of service to basically be the equivalent of a resource-based adjuster on the PLI, and if we wanted -- we could drop risk of service and just say resource-based approach, and then make clear in the text that by resource-based approach, we mean something that takes account of the likelihood of a claim or the likelihood of pay-out at the procedure level. That's at least what I was intending and I don't know what the alternative --

DR. LEWERS: We can look at that language and not write it as committee. We could write it and bring it back as we're doing it. Kevin, you and I could sit down and possibly pull something together.

DR. NEWHOUSE: Anybody have any thoughts on this exchange?

Okay. We were up to page 11 and now page 15, it looks like.

MR. HAYES: Next overhead, please, Janet. We passed this one.

DR. CURRERI: Are we going to come back with a revised one tomorrow?

MR. HAYES: Yes.

DR. LEWERS: We'll try. We may not make it, but we'll try.

MR. HAYES: The remaining recommendations have to do with the sustainable growth rate system and these recommendations were discussed by the Commission at last month's meeting.

They say first that the Congress should revise the SGR to include measures of changes in the composition of Medicare fee-for-service enrollment; and secondly, that the SGR should include a factor of real GDP per capita plus an allowance for increases due to improvements in medical capabilities and advancements in scientific technology.

The wording of that second recommendation is I tried to capture what you said at the last month's meeting and that's what I came up with.

DR. NEWHOUSE: I can't remember now, does the text say that we do this on the PPS update with the STA?

MR. HAYES: That comes up later in connection with the correction of estimates.

DR. NEWHOUSE: I was just thinking. It

potentially strengthens this to say you do this on the hospital side.

MR. HAYES: Good point.

DR. LEWERS: Is there any reason why we need two recommendations and can't combine this? Why did you separate it? Is it that critical an issue? I mean, in the text, it's two different.

MR. HAYES: These two recommendations here?

DR. LEWERS: Yes. In the text you have two separate recommendations.

DR. NEWHOUSE: Are you referring to the one on page 19 now?

DR. LEWERS: I'm looking at the one on page 15 and the one on page 16.

MR. HAYES: There's a graph associated with the second recommendation that shows trends in volume and intensity per beneficiary and talks about how that compares to real GDP per capita. In the case of changing the SGR to address changes in the composition of fee-for-service enrollment, there's a little bit of an analysis there with a couple of tables.

DR. LEWERS: So you're looking at the narrative?

MR. HAYES: Yes, just trying to fit the recommendations with the narrative.

DR. LEWERS: I have no problem with that. That's fine.

DR. LAVE: There is a question here about -- I mean, it's probably too late to touch it, but we did have that subjective statement in the earlier paragraph. We talked about big SGR as opposed to the physician SGR. Do we want to link them at all or basically, since the SGR is there and this would improve it, we feel comfortable with the improvements and funding of the big issue?

DR. NEWHOUSE: And what's the big issue?

DR. LAVE: Remember we talked about having something for everything?

DR. NEWHOUSE: This is the Peter issue?

DR. LAVE: This is the Peter issue.

DR. NEWHOUSE: So you mean you want to say if there is going to be an SGR -- well, the SGR is in law.

DR. LAVE: No, no. I just wanted to know whether or not we wanted to note that there was a linking between

this and what happened prior or just basically keep this the way it is.

MR. MacBAIN: I think because this may get read by itself, depending on the audience, it's worthwhile having the arrow point back saying this is what it is, but we really think it ought to be more broadly based, and by the way, we're not real happy about having this thing mindlessly driven by the GDP either, which was, I think, Peter's factor.

DR. NEWHOUSE: By the way, would this require a statutory change, the first one? I mean, the second one clearly would, but the first one, to account for composition?

MR. HAYES: My thought would be that it would because the BBA was very specific about the factors to be included in the sustainable growth rate itself. It was four things, changes in fee-for-service enrollment, real GDP per capita, volume regulations, and fees.

DR. NEWHOUSE: This is a recommendation to the Congress.

DR. ROSS: We will be doing that on all the

recommendations. It now says things ought to be done and the actors will be paid.

DR. NEWHOUSE: I'm not sure I heard final sort of agreement -- other than editorial pointing back to the allocation, how strongly do we want to --

DR. LAVE: I think that this is okay, but there ought to be a comment that linked it back.

DR. NEWHOUSE: I think we need a broader discussion of the Peter principle, so I would not get into that issue here.

DR. ROSS: Clever readers will, however.

DR. NEWHOUSE: That's all right.

DR. KEMPER: And should.

DR. NEWHOUSE: Obviously you put Peter in that category.

DR. WILENSKY: Page 19.

DR. LEWERS: Gail, before we go to 19, can I just make a recommendation that on the bottom of 17, the footnote that's there, I think, is a very important footnote. I don't know if that's what Joe was talking about earlier about moving that into the text?

DR. NEWHOUSE: Yes, I was. I'd forgotten the footnote was there, but yes.

DR. LEWERS: That should go in the text and not a footnote. A lot of people don't read footnotes.

DR. NEWHOUSE: Only the clever ones.

DR. ROWE: The accountants do.

DR. LAVE: And the lawyers do.

DR. NEWHOUSE: They put everything that's important in the footnotes.

Okay, the time lags. This is the lag times oscillation point. Everybody's comfortable with this?

DR. LEWERS: I'm comfortable with trying to get it all on a calendar basis, or at least a single-time basis, but does this give them time to do the projections? I mean, we've just gone through this with the plans and not having the right time frame because it's May. I mean, everything is due August the 1st, I believe, and if it's due August the 1st, is that going to give them time to have sufficient data from that calendar year or are we going to have the same problem that we have with the plans and we're now saying, you'd better look at another month?

Is a calendar year the right time? It should be all at one time frame, but is calendar year the right time?

MR. HAYES: What we talk about in the text is the need to estimate expenditures where we don't have the data available, where data are not yet available to say what the actual expenditures were during a previous time period.

In this case, let's think about this a moment. We are going to be, as you say, in August, calculating a conversion factor update for the following calendar year. At that point, we will have -- let's think about this. We will have claims data.

Let's say we were doing this this year. We're doing it this coming August. We will have -- there should be claims data available at least for all of calendar year 1998. We should know what the expenditures were through calendar year 1998 at that point in time.

It would be necessary then, as I discuss in the text, to estimate expenditures for calendar year 1999 and calendar year 2000, the year when this conversion factor update would actually be implemented.

DR. LEWERS: So you're saying a calendar year is

not a problem?

MR. HAYES: I'm saying that estimates will be necessary in order to bridge gaps between when data are available and when you need to do a conversion factor update.

DR. ROSS: But that's always needed.

DR. CURRERI: There's essentially a two-year gap in information?

MR. HAYES: That's right.

DR. LEWERS: I was just asking the question. I don't know the details of that. I just --

DR. NEWHOUSE: We know the present system bakes in some oscillation that's not helpful.

DR. LEWERS: Right.

DR. ROWE: And the idea is to get rid of that.

DR. NEWHOUSE: Right.

DR. ROWE: What's the adverse effect of the delay? Over time, it really doesn't matter, does it? Isn't it more important not to have the oscillation?

DR. NEWHOUSE: That's what I would have thought.

DR. LEWERS: I would agree. I'm not questioning

that. What I'm saying is, should we say on a calendar year basis or should we say at a single point in time.

DR. NEWHOUSE: You mean, like should it be March 1 instead of January 1?

DR. LEWERS: I don't know what the date should be. We've just gotten into that problem. We spent hours discussing that today.

DR. NEWHOUSE: What if we just said annual basis instead of calendar year?

DR. LEWERS: An annual basis or whatever is fine with me. That was my point.

MR. HAYES: The reason to say calendar year basis is because the conversion factor update itself is applicable to a calendar year.

DR. NEWHOUSE: And that's in the statute. Okay. Then do we mean time lags should be reduced or should be eliminated?

MR. HAYES: Well, if you read what I discuss in the appendix, you'll see that there's still a potential for -- I don't know whether you want to call them time lags or what, but there is still this matter -- let's say in the

case of these estimates that we were just talking about.

If we're wrong, then that in itself, those estimates in themselves, can introduce some oscillation if they are wrong.

DR. NEWHOUSE: I understand that.

MR. HAYES: So that to me then was -- well, I felt uncomfortable saying eliminate time lags because to me, that estimation introduces a timing issue. It's not necessarily a time lag, but it's a timing issue.

DR. NEWHOUSE: All right.

MR. MacBAIN: On the footnote on that page --

MR. HAYES: What page are we on?

DR. WILENSKY: 19.

MR. MacBAIN: Still 19 where it says HCFA simulations show that the mismatch is minor. What does that mean in the context of the graphs that show that the oscillations are significant?

MR. HAYES: The meaning of this footnote is that there is not as much volatility, or at least historically, there has not been as much volatility in the SGR, enough volatility in the SGR rather, to introduce the kind of

oscillation that we see just because of the mismatches in time periods.

If the SGR was changing radically from one year to the next, it could introduce some of this kind of oscillation problem, but that's not what we -- we don't see the kind of oscillation coming from the changes in the SGR that we see from mismatches in time periods. I don't know whether that was clear or not.

MR. MacBAIN: I thought the whole problem was the mismatch in timing.

MR. HAYES: Yes, it is. But the mismatches in time periods problem that we're dealing with here is that we're calculating an update adjustment factor for a year that ends on March 31st, and we're applying the information from that update adjustment to a calendar year.

And so, that's introducing some error in our update adjustment, which over time creates a problem.

DR. ROWE: I know your problem. You need smarter commissioners. Shall we make a recommendation to that effect?

[Laughter.]

MR. MacBAIN: I think I understand the problem, but my concern with that is the apparent dichotomy between the problem stated in the text and then this disclaimer that appears to say HCFA doesn't think there's a problem.

MR. HAYES: Right. The bottom line is that what we're saying in the recommendation is that all of this stuff should be on a calendar year basis.

DR. NEWHOUSE: Annual basis.

MR. HAYES: So while HCFA has found that this is a small problem, fine. Small or large, let's just put it all on a calendar year basis.

DR. NEWHOUSE: Calendar year basis.

MR. HAYES: So if you think that the footnote is problematic, get rid of the footnote.

MR. MacBAIN: I just don't like the footnote.

MR. HAYES: Easy to do.

DR. NEWHOUSE: Prediction error correction.

DR. WILENSKY: Any additional comments on the chapter in the text? We have passed out a copy of the revised Medicare+Choice recommendation. Let people look at them and discuss them tomorrow. We're not going to try to

have this discussion tonight.

DR. ROWE: You want to do these now?

DR. WILENSKY: No, we're not going to discuss this now. You may ponder this over the nighttime hours.

DR. ROWE: What time do you want to start tomorrow?

DR. WILENSKY: Why don't we start at 8:30 in executive session and we can review this or we can just start in open session.

DR. WILENSKY: Let me open it up for public comments with the patient people here leave if they wish to. Sharon?

MS. McELRATH: I'm mindful about Dilbert's law about not delaying dinner or the end of a meeting. I just wanted to say, there were a lot of comments made today about the problems of having a formula-driven update, and of course, that is exactly what we have with the SGR.

It seems to us that one thing that you could do that would help a little bit, we are very pleased with the changes that you have made. You have done a lot of things that will improve the SGR.

But the one additional thing that we think would be really important is to look at what result you're going to get sometime before it appears in a rule in November after Congress has already gone home and after no one can do anything about it.

So what we would like to see is the restoration of the rule that was in place with the MVPS where HCFA was supposed to provide in April an estimate of what the update was supposed to be and then PPRC evaluated that, said it's good, it's bad, you ought to change this, you ought to raise the primary care part, you ought to lower the surgery, or whatever, but just so that somebody reviewed it before it just automatically took effect.

DR. WILENSKY: Actually, I agree very much with that suggestion and I think we should add it.

DR. NEWHOUSE: Can Kevin draft some language that we could take up tomorrow?

MR. HAYES: Sure.

MR. DIKEMAN: I'm Zack Dikeman. I'm with a firm called Center for Health Policy Studies, which is a research and consulting firm. This is just sort of a general

comment, perhaps about the role of MedPAC.

Much of our work relates to looking at and assisting the private sector, providers, payers, purchasers, and we do some work relating to Medicare, too. But what we appreciate is that Medicare has had a significant impact on what is happening in the private sector.

But what is happening in the private sector in terms of processes, in terms of payment methodologies, in terms of relative prices, in terms of how things are done appears not to have that much of an impact on Medicare. And yet, they do interrelate. Just two little examples, one you've heard a lot about and one perhaps you haven't.

You were talking about sustainable growth rates or inflation adjustments, whatever you want to call them. In the private sector, for many health care plans, fully half of the inflation in the last two years is caused by prescription drugs. This is something that Medicare largely doesn't cover.

What we've seen is a real change in the production function for health care with probably a significant substitution of prescription drugs for other things. This

should have an impact on thinking about sustainable growth rate.

Another item that I want to mention is something that I know you've heard a lot about, Medicare risk pricing. We've done some work in Florida. What happens in Florida is that what the Medicare premium has done is one, reflect obviously an over-supply of providers, but perhaps even more, very substantial fraud and abuse where we're rewarding south Florida by the extent of fraud and abuse.

What you give to Florida, you take away from elsewhere. What we're doing now is subsidizing managed care plans in Florida who face a very competitive situation in their private business.

But what I think would be a useful role for MedPAC is -- HCFA certainly won't do this -- is to look at what is happening in the private sector, not just case studies, but the parameters, what people are paying, how they're paying it, and so forth, and its impact on Medicare and what things Medicare might do to optimize what it wants to achieve based on what's happening there, also.

Clearly, Medicare has very different objectives

than the participants in the private sector, but it should be aware and at least bring that information into its decision-making process.

DR. WILENSKY: Zack, could I ask you a question? Do you think that what's going on in Medicare+Choice in Florida with regard to fraud and abuse or payment is different fundamentally from what is going on in Florida in traditional Medicare since the rates flow directly from traditional Medicare? Is this a Florida comment or a Medicare+Choice comment?

MR. DIKEMAN: It's sort of a Medicare -- I think Florida is a very good example. What's happening in Florida is that what we're doing is subsidizing marketing. The marketing expense per enrollee in Florida may be eight or ten times what's available in areas with lower premiums.

Although the source of the high cost is fraud and abuse and excessive providers, the managed care plans are experiencing costs comparable to what their managed care experience for other enrollee groups, also. So what the managed care is experiencing doesn't reflect largely what is fee-for-service.

But my comment is about the system of pricing and how policy might be better informed if it was more aware of and took cognizance of what's happening in markets.

DR. WILENSKY: Thank you. Any other comments? We will meet in executive session at 8:30 tomorrow. We'll begin at 9:00 o'clock in open session. We're going to go back into an executive session during the lunch hour.

We may not get to both GME sections. I don't want to keep people past the time we've said that we will end on a Friday afternoon. Because they are not part of the March report, we will get to one if we can. I doubt if we will be able to do both. We're adjourned until 7:00 p.m.

[Whereupon, at 6:16 p.m., the meeting was adjourned, to reconvene at 9:00 a.m., Friday, January 15, 1999.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Crowne Plaza Hotel
14th and K Streets, N.W.
Washington, D.C.
Friday, January 15, 1999

The meeting in the above-entitled matter convened, pursuant to notice at 9:11 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair

JOSEPH P. NEWHOUSE, Ph.D., Vice Chair

P. WILLIAM CURRERI, M.D.

ANNE JACKSON

SPENCER JOHNSON

PETER KEMPER, Ph.D.

JUDITH LAVE, Ph.D.

DONALD THEODORE LEWERS, M.D.

HUGH W. LONG, Ph.D.

WILLIAM A. MacBAIN

WOODROW A. MYERS, M.D.

JANET G. NEWPORT

ALICE ROSENBLATT

JOHN W. ROWE, M.D.

GERALD M. SHEA

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P R O C E E D I N G S

DR. WILENSKY: Good morning, we're ready to presume the second day of our public meeting and preparing recommendations for the March report.

A couple of our commissioners and staff are somewhere on the Metro system, as probably are some of our normal attendees, but we'll welcome people as they come in.

Stephanie, would you please begin with the PPS-exempt presentation?

MS. MAXWELL: Thank you. I'm going to start off the session by briefly describing some financial trends concerning the three largest TEFRA groups. This information will provide a context, especially for the update recommendation.

After the background, I'll walk through the update and the target amount cap recommendations, then I'll bring up the recommendations that we discussed at the last meeting and open up for additional discussion you may have on those items. These are the range of those recommendations.

As we know, there are five types of free-standing hospitals that are exempt from the acute care PPS. This

overhead lists some key characteristics of the three largest classes, based on fiscal year 1996 cost reports. These facilities have experienced several common trends so far in the 1990s. Some of these include a growing Medicare volume and Medicare share of total volume, declining average lengths of stay, declining inflation adjusted costs per case, and increasing inflation adjusted cost per day.

Total volume in these facilities has grown rapidly in the 1990s, about 6 percent a year in the psychiatric and rehabilitation facilities and about 18 percent a year in long-term hospitals. Medicare volume has grown a little faster.

As you would expect, rehabilitation and long-term care facilities are the most Medicare dependent of these three groups, with about 70 percent of their volume coming from Medicare patients. The average length of stay has dropped at a fairly steady pace for the rehabilitation and psychiatric providers to about 15 or 16 days in 1996, but stays have remained a pretty stable 33 days in the long-term care hospitals.

DR. ROWE: That's the length of stay for the

Medicare beneficiaries in that hospital, or for everyone in those hospitals?

MS. MAXWELL: That's right, the Medicare.

After adjusting for inflation, Medicare costs per case have actually dropped steadily among psychiatric and rehabilitation facilities, but the remain about the same in long-term hospitals. We see the resulting increase in cost per day at about 3 percent above inflation each year in those classes.

The financial performance of these providers has improved over the years, as measured by payment-to-cost ratios by the shared facilities paid less than their costs, and among those providers by the share of costs that were in excess of their targets.

As we see here, the average payment-to-cost ratio for rehabilitation facilities reached 1.05 in 1996. Payments exceeded costs for psychiatric and long-term hospital providers for the first time in 1995. In '96, payments were 1 percent over costs for psychiatric facilities and 2 percent over cost for long-term hospitals.

As we've shown in prior ProPAC and MedPAC

analyses, a significant determinant of the financial performance is the age of the provider under the TEFRA system. Roughly half of the current providers were established before TEFRA was enacted. Providers that came online after that have had some influence over their initial costs and over setting the payment limit.

There's been a growth of new facilities, particularly in the 1990s. About one-fifth of rehab units came in after 1990. About a third of all psychiatric units came in after that year, as did over half of all long-term hospitals. As this overhead shows, the payment-to-cost ratios are generally higher among the newer facilities and the share of facilities paid less than their costs is generally much lower among the new facilities.

Some of the BBA provisions concerning these providers are designed to reduce the payment disparities between the older and the newer providers. These provisions include the target amount caps, the re-basing option, and the update formula. As we see on this overhead, the update formula in the BBA allows for a zero update for those facilities whose costs are less than their limits. They

would be on the left side of the graph and further down.

The formula allows facilities an update only if their costs are over their limits. For example, if a facility's costs exceed its target by less than 10 percent, it's update ranges from one-tenth of 1 percent to up to 2.15 percent, depending on how much exactly its costs are over its target.

DR. ROWE: This is all costs, Stephanie?

MS. MAXWELL: Inpatient operating costs.

DR. ROWE: So if, you know, yesterday we were talking about interest rates going down, so that those costs, the debt service costs might go down for a while at some institutions if they refinance or something, does that get reflected in this? Is that one of the costs that gets included?

These are patient care related costs, labor, things like that?

MS. MAXWELL: That's correct, it's the latter. Capital costs were paid 100 percent up until the BBA and now they're subject to a reduction in the BBA.

DR. ROWE: So that's not included in this?

MS. MAXWELL: Correct.

DR. ROWE: This is operating?

MS. MAXWELL: Correct.

As you can see, if a facility's costs exceeds its aggregate target by 10 percent or more, its update is the market basket. The formula is based on the market basket forecast and the updates in this overhead were calculating assuming the fiscal year 2000 market basket forecast, which is 2.4 percent.

The components of the Commission's update framework is very similar to the PPS hospitals. Since they were discussed in detail yesterday, I'll just summarize the component amounts today. The difference between HCFA's and MedPAC's market basket is negative .1 percent. A correction for the forecast error for fiscal year 1998 does not apply, since the BBA had actually mandated a zero update for that year.

The S&TA staff had estimated an increase up to .2 percent for Y2K system changes. Recalling yesterday's update discussion, the Commission discussed an increase of up to .5 percent for Y2K systems changes in the PPS

hospitals. An increase of .2 percent would result in a factor in the update of 2.5. If you increased for Y2K at .5 you would have an update factor of 2.8. Again, that amount would be plugged into the BBA formula.

At this time, I'd like to ask if you want me to go through all of the recommendations or if you want to take them one by one?

DR. WILENSKY: What would the Commission prefer?

DR. LAVE: One by one.

DR. WILENSKY: To remind commissioners, in your chapter, in addition to what Stephanie will put up, there is a summary on the back side of the 1998 recommendations. You have a summary of the 1999, as well as in the body of the text, depending on how you want to look at them, either in the context of the text or outside of it.

MR. SHEA: Stephanie, can you clear up one confusion I have? The first line, the 2.4 percent, is market basket?

MS. MAXWELL: Yes.

MR. SHEA: So the bottom...

MS. MAXWELL: The bottom represents the market

basket when you take out the .1 percent for the differential between HCFA's and MedPAC's market basket. And then if you added the .2 for S&TA, a minimum of .2, you get that 2.5.

DR. NEWHOUSE: Stephanie, can we talk about Y2K a minute? To what degree would the rehab and psych units be folded into what the hospital was doing? And to what degree do they have unique problems?

MS. MAXWELL: We discussed that on the staff level and the consensus was that -- and you may have a different opinion, but the consensus was that the PPS update for the Y2K reflected the PPS costs and would be an increase that would fold in only to the PPS update. And allowing the update and the PPS-excluded would address the costs that, in fact, are not a part of the PPS payments, even though they are one facility.

DR. NEWHOUSE: That's not my question. If I'm fixing my billing system, this is not the case, I'm using the billing system for the whole hospital and once I've fixed it I've fixed it? Some of the people that are closer to hospitals than I am need to speak.

DR. ROWE: I think you're right.

DR. WILENSKY: Except that, of course they're not units of hospitals.

DR. NEWHOUSE: I understand that.

DR. WILENSKY: My sense would be, to the extent that we're talking about units in larger hospitals, depending on how centralized the billing is, some of the costs would be absorbed by the larger unit. But presumably some equipment costs, and depending on how decentralized the billing is and the computer systems that are used, which might depend on the decentralization of the parent group, as to whether or not they would also have decentralized and therefore Y2K costs.

But obviously the free-standing units would have all of the kinds of Y2K that hospitals would have, as well.

DR. LONG: Would that be true? I mean, we're talking about much more homogenous, even sort of single specialty kinds of activities here. I don't think we have the degree of complexity that we would have in a PPS hospital.

DR. WILENSKY: Maybe long-term care, but I think that's not correct for rehab hospitals.

DR. ROWE: I think it's going to vary, but in terms of the way it's organized in the real world, to give some specific examples, while New York Hospital has a very large psych hospital, it's on a different campus.

DR. WILENSKY: That's what I was talking about, the relationship with this facility.

DR. ROWE: And while the Massachusetts General Hospital as the McLean hospital as its psychiatric entity, it's 25 miles away. And it's got its own infrastructure for billing, et cetera, et cetera, for its psych. And many of the rehabilitation activities and facilities that are on the license of a given hospital are anatomically different, structurally different.

Now many others are not. But it sort of varies.

DR. MYERS: Jack other than billing, though in most cases that would probably be outsourced, what Y2K issues would a McLean or a free-standing psych hospital have?

DR. ROWE: Let me give you the simplest possible example. Every elevator has to be changed or they're all going to stop at midnight, because they all have chips on

them that are going to say they haven't been maintained in 100 years, and they stop automatically if they haven't been maintained in six months.

If you have a separate facility, you have extra elevators. It's different than having the rehab unit be the seventh and eighth floor of a big hospital building and if you're fixing the elevators in a big hospital building, the rehab is taken care of. I think that's the point.

So if you have a separate anatomic facility, you have all the infrastructural Y2K things.

MS. ROSENBLATT: The point of everything you just said --

DR. ROWE: So don't be on an elevator. That's a place not to bee.

MS. ROSENBLATT: I'm going to raise the same point I raised yesterday. If we're talking about a Year 2000 update, you've got to fix the elevators before 1/1/2000, so I have difficulty understanding -- there should be almost nothing --

DR. ROWE: We should have had this discussion last year, but we didn't.

MS. ROSENBLATT: I remember bringing it up. I know it was in the narrative last year because my company was working on it last year. So it was in there. I mean, it wasn't an explicit factor, but I do think that it should be very little for 2000.

I mean, I understand the point that Jack made yesterday that the hospitals who have delayed doing this maybe had to prioritize and I agree that life-saving stuff should get first priority.

MR. SHEA: We may be making this more complicated than it ought to be, but if this is a per unit payment that we're talking about, why would we do anything different than what we did yesterday, whether it's free-standing or part of the facility? Because if it's part of a facility for those units of care that happen there, they should be contributing to solving the overall problem in the same way somebody in the pediatric unit.

DR. ROWE: My view of it is, having thought about it a lot, is that there's a tremendous variety in the way these things are organized. We can make cases for or against any extreme here. I mean, I think we should be

consistent with what we do, to whatever extent we can be. If we made some Y2K adjustment, Alice's concerns notwithstanding, on the stuff yesterday then it probably should be today. I don't understand how it couldn't be. It doesn't have to be a lot or we should undo what we did yesterday.

I mean, I think we have to have some consistency.

DR. LAVE: My comment really was a reaction to Alice's comment. That is that these rates go in effect as of October 1st, 1999, so that we do have some of 1999 year involved in doing this and I think that we should take that into consideration.

DR. WILENSKY: And to the extent there has been unfortunate delays being reported, they will probably do crash spending the second half of 1999.

DR. LAVE: So I'm with Jack. I think we ought to increase the S&TA allowance.

DR. NEWHOUSE: If I bought my elevators after a certain date, is there ever a time when I can buy elevators that I don't have the Y2K problem?

DR. ROWE: Sure.

DR. NEWHOUSE: What was, roughly, that date?

DR. ROWE: And I can give you some business cards of some people that would be happy to help you.

DR. NEWHOUSE: Here's what I'm getting at, in several of these segments there's been a lot of recent entry.

DR. ROWE: Absolutely.

DR. NEWHOUSE: And the question is, if I built my hospital say in 1995, do I have a Y2K problem?

DR. ROWE: Yes.

DR. WILENSKY: You do until you know otherwise. Basically, at the very least, you need to roll the clock forward and check it or you don't know you don't have a Y2K problem.

DR. ROWE: I think an aspect of this problem which is not often considered but which we're dealing with, just for information's sake, is the professional liability problem. I mean, a lot of people say well, we shouldn't give the hospitals the money because they're not going to spend it on this Y2K stuff or this MIS infrastructure stuff anyway.

They will, because there's a big professional liability -- our professional liability insurance company sent us a letter saying can you assure us that you have taken care of all of these things? And if not, when will you take care of them? If not, you're not covered. So there is that effect.

One other thing about this is that, because somebody said yesterday -- and I thought it was a good comment. I think Woody said, there's a lot of stuff getting funded in the Y2K window that wouldn't otherwise have been able to find itself a budget. I think that's true, and I think what that is is stuff that's all MIS stuff that would get done, it would just get done a year or two later. And people are saying if they're spending all this money on infrastructure and MIS and Y2K, I might as well fix the system kind of stuff.

Some of that stuff, there probably is some data on that. There might be less expense in the year after that or the year after that, because people said well, I'll do it all at once.

DR. WILENSKY: Stephanie, do you want to -- where

are we with regard to -- is there any further discussion or do you want us to right down to the bottom line?

DR. LAVE: We want to put S&TA up a little, I think is where we are, isn't it?

MS. MAXWELL: Yes, I'm wondering what the range --

DR. WILENSKY: .5 to one? Is that where we were yesterday?

DR. ROWE: No, you would add .3 she said.

MS. MAXWELL: Right. So the increase would be .5 instead of .2.

DR. NEWHOUSE: What's in the BBA?

MS. MAXWELL: The current forecast is 2.4, so if you added .5, then you would --

DR. NEWHOUSE: The default value? That's my question.

DR. WILENSKY: The BBA default value is?

MS. MAXWELL: Is the forecast, the market basket forecast which would be, at this point, 2.4.

DR. MYERS: Is the market basket exclusive of Y2K? Doesn't everybody have Y2K? I'm still stuck on this -- what are we doing?

MR. JOHNSON: We're being consistent.

MR. MacBAIN: We're being consistently wrong.

[Laughter.]

DR. WILENSKY: That may be.

MS. MAXWELL: So we'll go with --

DR. WILENSKY: That actually is an interesting point.

DR. LONG: The market basket is just the expected increase in prices of the existing array of resources.

DR. WILENSKY: Right.

DR. MYERS: Which we can expect an increase in cost, which would include or would --

DR. LAVE: No, it would not include capital update.

DR. LONG: No, prices for the same thing.

DR. WILENSKY: Right, it's inflation.

DR. LONG: It's inflation. It's prices for the same thing.

DR. NEWHOUSE: It's not like wage increases.

DR. LONG: This is new stuff.

DR. MYERS: No, the same thing requires a

different set of inputs. To get the same thing you need --

DR. NEWHOUSE: But those different inputs aren't in the market basket that's being tracked.

MR. JOHNSON: Isn't there a parallel here to drugs, that just regular drugs are included in the market basket but new drugs are in addition to it?

DR. NEWHOUSE: Yes.

DR. ROWE: That would be S&TA.

MS. MAXWELL: Right.

MR. JOHNSON: And I view this as being the same sort of thing. We have information system, we have computers.

DR. NEWHOUSE: I would have assumed computers were in the market basket, but that doesn't necessarily go to Y2K.

MR. JOHNSON: But those next 100 year chips aren't in there.

DR. WILENSKY: I think there's a claim for a legitimate short term increase.

DR. NEWHOUSE: A one-time increase?

DR. WILENSKY: One or two times. So the default

is 2.4?

MS. MAXWELL: Yes.

DR. WILENSKY: So we are now slightly above that.

DR. CURRERI: Don't you think we should put in the text what this S&TA is for and make certain that we put in the text it's a one time infusion?

DR. WILENSKY: Yes.

DR. CURRERI: So next year we don't redo it again.

DR. WILENSKY: That will clearly give us a higher recommendation now than what the default recommendation is, by a few tenths of a point.

MS. MAXWELL: That's right. So if you had the .5, you would go up to 2.8, because of the 2.4.

DR. WILENSKY: As high as 2.4.

DR. MYERS: In subsequent years do you back out the one-timers?

DR. WILENSKY: Yes.

DR. NEWHOUSE: That would have to be on the hospital side, too.

DR. WILENSKY: Remember for next year.

MS. MAXWELL: Thank you.

DR. WILENSKY: So even our low end is slightly above the default.

DR. ROWE: No, the low end would be 2.3.

DR. WILENSKY: No, we've raised it because of --

DR. NEWHOUSE: It would be 2.8.

DR. CURRERI: 2.8 is the high end and 2.6 is the low end, if it's .3 to .5.

DR. WILENSKY: Right. I thought it was .2 to .5.

MS. MAXWELL: Right, your low end would be 2.5.

DR. WILENSKY: Right.

MS. MAXWELL: And the high end would be 2.8.

DR. WILENSKY: And the default is 2.4.

MS. MAXWELL: That's correct.

DR. WILENSKY: Thank you. Everyone comfortable with our recommendation?

[No response.]

DR. WILENSKY: Next one?

MS. MAXWELL: This draft recommendation deals with the BBA's provision and it places a cap on the target amounts of the existing psychiatric, rehabilitation and long-term care providers. These amounts were determined by

taking 1996 cost reports, identifying the 75th percentile target amount, and then adjusting those amounts for inflation by the market basket.

The BBA did not authorize the Secretary to adjust the caps for wages, although they did wage adjust the caps that they imposed on new PPS-exempt providers. As a result, this particular cap on the existing providers is the only prospectively determined Medicare payment or payment limit that does not account for wages.

About 75 percent of these PPS-exempt providers are in urban areas. If the caps are not adjusted about 7 to 8 percent of both urban and rural providers would have their base payments reduced to the cap. If the caps were adjusted, the rural providers would have a lower cap and about 12 percent of them would exceed the cap.

Last year the Commission recommended wage adjusting the cap largely on the argument that Medicare payments and limits are wage adjusted in all other areas. I would yield for discussion.

DR. ROWE: As I recall last year, we had some visitors who basically told us last year this is an

oversight in the BBA, Congressional staff. What happened was HCFA said that it would require legislation to fix it and the legislation was shot down.

DR. NEWHOUSE: If there were a technical bill, this would presumably be in it.

DR. WILENSKY: Is there any interest in not including it again this year?

MR. SHEA: I definitely think we should do it, but someday it would be good to ask these hospitals whether they actually pass on the money to their workers. This is an industry that has distinguished itself in wage inequality.

DR. ROWE: There's a long pathway. It's like we could ask the HMOs if they pass on the money to the hospitals and the hospitals if they pass on --

MR. SHEA: You ask that question. I'll ask this question.

DR. MYERS: You could ask one of the purchasers who are getting value throughout the entitlements chain, as well.

DR. WILENSKY: I think we'll move on.

[Laughter.]

DR. ROWE: That's leadership.

MR. SHEA: We can put a footnote in there, we're going to audit that.

MS. MAXWELL: I also want to review the draft recommendations presented at the last meeting and yield, Dr. Newhouse, to additional discussion you may have on these recommendations.

One of the recommendations is about the current PPS study. HCFA and its contractors are still in the early stages of this. Right now they're figuring out the 50 or so facilities that they're going to go into in order to collect the MDS and the staff time data on a total of about 2,000 patients. The study contractor is using Medicare data now to work out the sampling strategy.

HCFA has identified several criteria by which they want the sample stratified. These include urban/rural location, bed size, number of patient days, occupancy rates, ownership and available staffing and services.

We've been consulting with an AHCPR statistician who helps develop the sampling strategies for that agency's nursing home studies. Two main points about the rehab study

arose from those discussions.

First, it was strongly recommended that for any given total sample size it would be better to increase the number of facilities. So using the 2,000 patient study size as an example, the classification groups and the weights would be improved by sampling 25 patients at 75 facilities rather than the current plan of about 40 patients at 50 facilities.

It was also strongly recommended that case-mix itself should be the priority stratification criteria. And given that stroke and orthopedic diagnoses represent well over half of the rehabilitation facility patients, it was recommended that the study undersample those diagnoses so that there would be a sufficient number of patients and the rarer conditions in the study.

The recommendation also encourages HCFA to exploit the repository of FIM-FRG data. There are several ways that that data can be used to enhance the development of the final rehab PPS, and these are discussed in the chapter.

At this point, I'd like to yield to any additional discussion on this recommendation.

DR. NEWHOUSE: I guess my question is, what do we think we're gaining from the study? If the FIM-FRGs are doing a good job on a case-based adjuster, what's the value added here?

MS. MAXWELL: The value added of the study is the staff time measurement. The FIM-FRG uses the allowed charges from the --

DR. NEWHOUSE: I understand that but I thought we were comfortable with FIM-FRG. Are we saying that we want to junk FIM-FRG and we ought to have a big study of staff time? I mean, this is already $1.7 million, some of which may have been committed --

DR. WILENSKY: And it's inadequate

DR. NEWHOUSE: Which is inadequate, so we're presumably talking about a substantial study in terms of research dollars.

DR. WILENSKY: I also was a little confused about it from discussions I had had with people from the rehab industry. It sounded like both our assessment and their assessment was that FIM-FRG worked pretty well and that the number of observations, given all of the codes that need to

be identified, is in fact very small given the statistical needs of the study.

But I also had the question that Joe has raised, which is if there is general satisfaction with FIM-FRG and we have all the difficulties in general of coming up with agreeable patient classification systems, why are we doing this?

MS. MAXWELL: There are two answers. One is, recognizing that HCFA has already committed funds to this study and has the contractor for it, people who are generally supportive of the FIM-FRG study were looking for a way to best use the resources that that study represented. That is what led to recommendations or suggestions which you've received, I understand, from the industry as well as what we've discussed in the past, suggestions to focus on the non-therapy ancillary elements of patients costs.

That would be an additional element garnered from the study if it was slightly reoriented.

DR. NEWHOUSE: Sounds like it's more than slightly reoriented. It sounds like you need a massive increase in sample size.

MS. MAXWELL: You could argue that even if it wasn't reoriented and HCFA was just going to continue with its original plans.

DR. LAVE: I think that we should decide one of two things. We should decide if we think that the FIM-FRG way of -- their basis for doing a prospective payment system is appropriate for rehab hospitals. We may want to say that that's a good idea and worry around that.

My understanding also is that the nursing homes that do a fair amount of rehab don't have the appropriate data to, in fact, worry about the upper level rehab people in those cases. So that they may want to focus their study basically on the RUG-based rehab stuff in the nursing homes unless we want to make a recommendation that would say that the nursing homes ought to identify those patients which are similar to those who are treated in a rehab setting and use the same system for those people.

But my understanding is that the RUGs -- that there's a lot of rehab that goes on in skilled nursing homes and that the upper level RUGs don't actually have enough information for them. So that there is a problem with

applying the RUGs to very intense rehab patients in nursing homes.

There also is this issue what do we want to do with the rehab hospitals? And I think that we may want to focus the stuff on the nursing homes away from the rehab hospitals and then worry about the kind of system that one would want to have that would prevent inappropriate gaming on site of care, given this distinction in the types of payments that, in fact, one has.

So I think that that would be another way of using the money that's already been committed to do something that might make more sense if we think that the FIM-FRG, which seems to have been tested, it seems to be --

DR. NEWHOUSE: Everybody but HCFA seems to be happy.

DR. LAVE: Everybody but HCFA seems to be relatively happy with it. So that would be another way to think about how to handle this problem.

DR. ROWE: The problem is we're all investigators. We're all researchers and we can't resist trying to redesign the study or reinfluence the study.

DR. WILENSKY: No, it's more serious than that. The issue is that the study is being proposed to replace a classification system that appears to have done a reasonably good job, and that the study that is being proposed has some serious problems. That is, it has an inadequate sample to do the job that it's going to be asked to do.

So we're not sure why they're doing it, but if they're doing it to replace an existing classification system, then it's got to be able to carry that job or it's got to do a different job.

DR. ROWE: Accepting that, it seems like we're sort of making a deal with ourselves. I mean, if we're going to make a comment about this, the last we can do -- I mean, the guys at HCFA are as smart as we are and they're as well trained, and they evidently want to go ahead and do this. We should at least sit down with them and ask them, rather than ask Stephanie, to defend the study.

MS. MAXWELL: Absolutely. The basis of the study is because they want to have a conceptually common payment system across the post-acute care sites, which includes the data coming off of the MDS-PAC and it includes a per diem

payment unit.

DR. WILENSKY: We would like that if we thought it were possible to do appropriately. My sense is where we have left our discussions is that there is not a classification system that, in fact, works well for skilled nursing facilities in general and rehab.

DR. ROWE: That much we can stipulate. That much we've heard.

DR. WILENSKY: So the question that I thought Judy was raising is that if that's the case, should we try to fix some of the RUG classification, higher acuity classification that incorporates the rehab patients so that we think we are paying the skilled nursing facilities appropriately, particularly for those high acuity patients, to continue with the FIM-FRG classification system for rehab which we think does a reasonable job for those hospitals, and try to figure out a way to prevent gaming between movement of patients from one facility to the other.

We would, I think, all prefer to have a single classification system but we don't think that there is one that will do as well as these two if they were appropriately

modified. And in fact, with regard to your comment about what HCFA is doing, there have been in the past times where the commissions have strongly disagreed with a particular direction that HCFA has taken in terms of developing systems.

For example, in the relative value scale, the practice expense study was an area where the PPRC commission had assessed and made recommendations that were contrary to what HCFA was doing.

So we certainly may need to make sure we understand what they're doing before making the recommendation, but I do think that if we think there are better ways to approach the strategy, we should make those recommendations.

DR. CURRERI: I can't agree with this recommendation at all. The first sentence says that we support HCFA's study. But we really don't support HCFA's study, or in my opinion we shouldn't support it. Because in the next sentence we say no matter what the outcome, it's not going to be statistically valid so it isn't going to help us.

So I think we ought to be honest and say that the recommendation should be something like MedPAC thinks that in the long run there should be common systems of classifying diagnoses across outpatient facilities and that currently --

DR. WILENSKY: Where possible.

DR. CURRERI: Where possible, and currently these don't exist. And that it may be very well that this MDS-PAC could be developed in years but it's going to take many, many patients and many millions of dollars. And until that time we ought to use one that is existing and we know that works.

I mean, I think that's the way we ought to approach it, rather than to say we support a study that we know is going to be statistically useless.

But I also think you should put your power analysis back in the text in here, to prove that it's useful because I thought that was really good. It didn't get in the text.

DR. LAVE: I basically agree with that recommendation which is what I thought -- I think that

they've already paid money for something and they could do something useful with that money by focusing on the high end RUGs. That was my point.

To come to Jack's point, I think the question that the Commission has -- there are two different views here. One view is do you want to take the post-acute institutional services and fund them on a per case basis? Or do you think it's better to fund them on a per diem basis?

Most of the discussion that we have had has, in fact, conceptually said that there are many advantages to focusing these as a per case system rather than a per diem system.

DR. ROWE: That's right. I think that's where we came out.

DR. LAVE: So I think that in our recommendation on the FIM-FRG that we ought to say that the Commission believes that for these sorts of providers that we believe it is more appropriate to have a per case system than it is a per diem system. If that's true, then the FIM-FRG follows as a per case classification system, and so we recommend doing that.

DR. CURRERI: Is there any reason why the skilled nursing facilities couldn't use FIM-FRG for rehab patients and use per diem on a temporary basis for their non-rehabilitation patients?

DR. LAVE: I think that should be a recommendation that we should make, is that -- I mean, we could think about making. That is, is it possible to identify comparable -- I mean, we had this discussion yesterday about patients, that there are places where only SNFs do this sort of thing, and that there may be somebody who could think about a demonstration project of implementing FIM-FRG in nursing homes and trying to figure out whether you could do that, if you could identify those patients --

DR. WILENSKY: Let me just clarify that.

DR. LAVE: Only for the high end rehab.

DR. WILENSKY: Only for the high end, so we would be suggesting making a recommendation that would suggest a demonstration to see whether the FIM-FRG classification system could be used appropriately for high end rehab patients in skilled nursing facilities.

DR. NEWHOUSE: Let me clear, these would be

patients in these 10 diagnoses who are getting three hours or more of therapy a day? And in the rehab they only have to be 75 percent in those 10 diagnoses. So what about the other 25 percent?

DR. ROWE: Be careful here.

DR. LAVE: We may not want to

DR. ROWE: First of all, I think you're recapitulating the discussion just as I recall. Remember, we had this discussion about rehab not on weekends and people would slide back and wouldn't it be more intense to rehab, it would be better to focus it on the case rather than per day. Ted told us about his experiences, et cetera.

But when you're saying the high end rehab, you mean the high end rehab of the patient population in the SNF?

MR. MacBAIN: Yes, of the RUGs.

DR. ROWE: As opposed to the high end rehab, which is the quadriplegic patient on ventilator --

DR. LAVE: Right.

DR. ROWE: So we need to be clear which high end rehab we're talking about.

DR. WILENSKY: For the individuals in rehab units in hospitals, Judy's recommendation would be we use FIM-FRG and case. What we're talking about now is high end rehab patients in skilled nursing facilities.

DR. NEWHOUSE: We're really talking about patients who could have gone to a rehab unit or hospital but didn't.

DR. ROWE: But wind up on a RUG rather than a FIM-FRG.

DR. WILENSKY: Right, because they're in a skilled nursing facility.

DR. ROWE: So the point is, that if a patient requires a certain degree of or type of rehabilitation service, then the payment should be based on the FIM-FRG regardless of the site of care.

DR. WILENSKY: Right, that's the idea.

DR. ROWE: That's the principle.

DR. WILENSKY: And then we would support a demonstration to see if that actually made sense when you put it in practice because while you would have the same classification system for a patient irrespective of site you would, of course, have different classification systems for

a single institution, which might raise its own issues.

DR. CURRERI: The only downside I can see of that is it forces a little more bureaucracy on the SNFs because they would now have to classify patients two ways, to see which way they fit in. But I think that's not insurmountable.

DR. NEWHOUSE: Maybe it would be simpler, or we could raise this as a possibility, to on the SNF side to just limit to the 10 diagnoses in patients that are getting three hours a day and not worry about the rest of the world. I mean, that would make it substantially similar, not exactly.

DR. CURRERI: I think my point is that I can't support this new study unless there's going to be significant resources to do it right so that we can come -- and it will still take five years to come out with a new system, I'm sure, at best.

DR. LAVE: But would you support their worrying about classifying -- I mean, they have a problem and it might be that you could do a better job with that sample if you were worrying about nursing homes. I don't know about

that, whether or not you would get useful information if it were targeted to nursing home patients. Would it still be too small?

DR. KEMPER: I agree both with Bill and Judy. I apologize for being late.

The one thing on how assertive to be on what to do with the high end rehab patients in SNFs, I think there are just a whole lot of issues that have to be worked out about that. So I think HCFA doing some analysis and considering a demonstration makes sense because I think there are a lot of things that could be done, a lot of things that have to be worked out, but I don't think we should leap right away to saying that the FIM-FRGs ought to be used in the SNFs.

It ought to be considered, and there's clearly an issue about substitution of site there that could become a problem that needs monitoring. But I would not jump whole force to that right away without some --

DR. NEWHOUSE: The recommendation is around the study, so what would you do for the moment? What do you want to do with the study?

DR. KEMPER: I agree with Bill on that. I think

what Judy suggested of saying straight out it should be an episode-based system and using the FIM-FRGs or some variant of it. And then with respect to the study, should focus on the high end patients in SNFs and whether a like system or that same system could be used there.

But that's where the study would be focused, is on those high end SNFs.

DR. NEWHOUSE: Let me raise an issue, if we're getting into SNFs, that I don't have a problem with what has gone so far, because I think you can clearly demarcate people that are in these 10 diagnoses who are getting three hours of therapy a day or more are going to be presumably there for a while.

But per case, for the SNF more generally, outside this kind of patient may be very problematic, I think. You may just spend your last day in a SNF and collect a separate per case payment.

So I don't think we want to start down a path of saying we think we're going to get to a per case system for everybody in all post-acute.

DR. LAVE: No, I don't think we were --

DR. NEWHOUSE: No, I know you weren't. I just wanted to be clear that -- all right.

So as I hear it, then we're recommending the study stop, in effect, this study, right?

DR. CURRERI: Or refocus.

DR. NEWHOUSE: Refocus how?

DR. LAVE: On the high end SNF rehab patients.

DR. NEWHOUSE: To adapt the RUGs to them on a per diem basis? Because I thought pending this demo -- I mean, if these patients are really the same patients, then the FIM-FRGs presumably work for them.

DR. LAVE: We don't need to worry about that problem --

DR. CURRERI: That's what I think you need to know, is are the high end --

DR. NEWHOUSE? What's not known? That's what I'm not --

DR. LAVE: No, no, they need to do something about the high end RUGs now because those patients are currently being paid under a per diem system.

DR. NEWHOUSE: Yes.

DR. LAVE: So as I understand it, they have to do something about that now. What we're suggesting is -- that's a current law problem, they've got RUGs there.

So that's where we're suggesting that they refocus their issue.

DR. NEWHOUSE: Is there a general consensus on refocusing the study then, to the high end RUGs, modifying the per diem part of RUGs to accommodate the high end people?

Now Stephanie, somebody is going to have to right the recommendation language. I assume that's you.

MS. MAXWELL: That's a good assumption. Could I clarify? When you're talking about refocusing the study for the high end SNF rehab patients, do you mean within the current RUG system?

DR. NEWHOUSE: Yes.

DR. CURRERI: I think what we're talking is --

DR. NEWHOUSE: There's actually two different recommendations. One is demo of FIM-FRG in SNF and one is a accommodating that patient who could have gone to the rehab facility within RUGs. That's the refocus the study to that

patient.

DR. CURRERI: But we're getting rid of what they really wanted to study all together.

MR. MacBAIN: I think we're talking about a new study here. The study that we started out discussing was this MDS-based study and now we're talking about something completely different, which is whether people in these high end RUG classifications could be paid for as equitable a basis or a more equitable basis using FIM-FRGs in the skilled nursing facilities.

I suspect in a lot of cases they really are the same patients because you've got so many errors where you don't have a rehab hospital where all these rehab patients are either going to be in an inpatient unit or in a SNF.

MS. MAXWELL: The main overlap is hip fracture and stroke patients.

MR. MacBAIN: There may be something to be learned from what sort of differentiation there is in areas that are served by rehab hospitals, and how are patients sorted out between those two. And so that makes it advisable to do this on a study basis first, rather than just making an

assumption and going in whole hog.

DR. LAVE: There is another question, and Stephanie, you may know the answer to this one. That is that there is the issue of the classification system, which is my understanding of what that study is about. But there also is the issue of implementing the MDS-PAC in nursing homes. That is, that an instrument which gathers information about patients and tells you something about those patients so that you can, in fact, look at what the patients look at according to this instrument and the different sites.

I don't think that anything that we have said would say that that is a bad idea or a good idea, to go ahead and implement that instrument. I mean, that's different from the $1 million study. I think that probably having that kind of data might not be a bad thing. I don't know, but we've not said they should not implement the MDS-PAC in the nursing homes.

DR. WILENSKY: I don't know that we've ever had any discussion or assessment of that.

DR. KEMPER: But we do have a recommendation on

that a little later.

MS. MAXWELL: That's right. As we presented at the last meeting, given this recommendation and given the next recommendation, it might appear that we would not be supportive of the MDS-PAC and the data collection across the sites.

DR. WILENSKY: Again, I thought that that was across all sites as opposed to maintaining them in the skilled nursing facility.

DR. LAVE: It's a data gathering instrument that tells you something about the nature of the patients in these different settings. And it asks certain types of information that allows you to use for -- I mean, it could also be used for looking at what happens in outcomes because you look at sort of the beginning and the end, sort of how people have changed, I think, over the period of time.

I don't know enough about how they've modified the MDS for the PAC part, but I just wanted to say that these recommendations that we've been making about payment classification systems in the study are not a recommendation about implementing the MDS-PAC.

DR. WILENSKY: Since that's the second recommendation after the one we're working on, why don't we wait and take that up which, in fact, basically says that, that the MDS-PAC is useful or would provide useful data irrespective of the payment system.

MS. MAXWELL: So the point of the study that was reoriented toward the SNF rehab patients would be that the current SNF-RUG system with its rehab RUGs were based off of basically a much earlier version of the MDS that had very limited information about rehabilitation oriented to patients --

DR. LAVE: And also, I thought, a small number of rehab -- to some extent, my understanding was, from reading what you said, is that the number of rehab patients in the study that classified the RUGS, these high end rehab patients, was really rather small. So that the payments associated with those is not very good under the RUG system.

If we only had RUGs and everybody was -- how good is that system for the upper end ones? And Peter, you know more about this than I do.

DR. KEMPER: It was originally developed for

Medicaid patients, or at least predominantly Medicaid populations. So in the total population, there aren't that many cases that rehab and certainly not high end rehab. So I think that refocusing makes sense.

But I also think we ought to stick with the recommendation to have common data across all settings, from rehab to home health. At least common core data. I could see that the high end rehab patients might -- we might need to collect additional data on them for clinical reasons and monitoring reasons, but at least a common core.

And I think we should stick with that and a lot of work has been done on the MDS and I don't see any reason to question that.

DR. WILENSKY: Do you have enough on this that we can move to the next recommendation?

MS. MAXWELL: Yes.

DR. CURRERI: We're actually then approving the second to the last recommendation on the second page there, at the top?

DR. WILENSKY: The one supporting MDS-PAC data collection across all post-acute care providers.

MS. MAXWELL: One recommendation before that, I can see an easy recommendation. The next recommendation had been about the payment unit and I assume we have decided.

DR. NEWHOUSE: So what has happened to the recommendation that says the Commission supports HCFA's study.

DR. WILENSKY: That is going to be rewritten and indicate the kind of study that we would like HCFA to do, or the demonstration we would like HCFA to do, which is to provide a demonstration on using FIM-FRG on high end rehab patients in skilled nursing facilities.

DR. NEWHOUSE: Rather than high end, I would say patients who are eligible for treatment in rehab units in hospitals.

DR. CURRERI: And the focus of this would be to see if these are comparable patients; is that correct?

DR. NEWHOUSE: Yes, it seems almost by definition they are. That's why I don't --

DR. WILENSKY: I think it is to try to see the implications of using a different payment system within the institution for what you think are the same patients.

DR. CURRERI: So you're going to compare this with per diem payments.

DR. WILENSKY: Just to try to assess what happens when you have two payment systems within the same institution.

DR. CURRERI: I do think there are two points, and I don't know how important this is, but my guess -- and this is only a guess. My guess is that what you said, Joe, is correct. That high end skilled nursing facilities, for the most part, would be the same as rehabilitation hospitals, with the exception of where you have a very large rehabilitation hospital in a metropolitan area where my guess is more severe patients would be -- because the beds were available, would be referred to that hospital as compared to -- that may be such a small number that it's not worth looking at.

DR. NEWHOUSE: They still have to be in this three hours of therapy a day or more.

DR. WILENSKY: On the other hand, I think the point of the demonstration is before we suggest the use of the two classification systems within the same institution,

we ought to see what happens when it is used because there may be some unintended consequences in terms of what goes on in the institution.

DR. NEWHOUSE: That's a different kind of --

DR. WILENSKY: That's why the demonstration is important.

DR. NEWHOUSE: That needs to be made clear.

MS. MAXWELL: Did I understand that you wanted the rehab SNF recommendation to be folded in with this recommendation? Or that could be a stand alone, itself?

DR. LAVE: Stand alone recommendation.

DR. NEWHOUSE: Stand alone.

DR. WILENSKY: Yes.

DR. ROWE: Do you need two separate recommendations, one for long-term care hospitals and one for rehab facilities? Aren't they both the same recommendation?

MS. MAXWELL: Maybe not any more. As you know, we haven't had a session solely devoted to the long-term hospitals and their issues. And part of that is because of the timetable, the BBA had not set forth an actual

implementation timetable for them. It just required a report to be submitted by the Secretary to the Congress this October.

We will have an opportunity to comment on that report at that time, as well. At this time, though, we would have fairly concrete details on the concept of HCFA's plans which, again, follows the MDS-PAC per diem payment unit. But again, we wouldn't have payment weights or classification groups now or in time for the report to the Congress to quantitatively compare with a DRG-based, case-based system that many of the industry support that has been designed recently.

So part of the issue here was whether or not you wanted to have a recommendation given the lack of time we've had to discuss fully the long-term hospitals. There can be a recommendation saying to look at both systems or generally all systems that are available. You could more strongly make a discharged-based recommendation, as you see in the text.

DR. ROWE: I think the rationale is the same. It's the same patients, so the rationale is the same to have

a discharge-based approach in these facilities as it is in the rehab. I was just wondering whether you could consolidate these two things into one recommendation and make it -- they basically say the same thing. I don't really care.

I guess the other option is to pull the long-term care hospital recommendation entirely based on the fact that the report's not out yet from HCFA and we haven't discussed it.

DR. CURRERI: But if I'm right in the TEFRA experience, the average cost or the target cost of the cap is much higher for long-term patients than rehab.

MS. MAXWELL: That's correct.

DR. CURRERI: So I think we're talking really about different population of patients. Most, as I understand it, are long-term ventilator support or that sort of thing.

DR. LAVE: They're not rehab patients.

DR. CURRERI: No, they're not rehab patients at all, so I don't think I'd lump them together.

DR. KEMPER: And we certainly haven't discussed it

at much length. So maybe we should just remain silent at this point.

DR. ROWE: We haven't discussed it.

DR. CURRERI: I don't see anything wrong with this recommendation, and all this recommendation is saying is that --

DR. WILENSKY: This is the next recommendation now, that you're talking about?

MS. MAXWELL: Yes, I'm sorry.

DR. CURRERI: Discharge-based prospective and we don't tell them how to do it.

DR. WILENSKY: I went to make sure people are looking at the recommendation that we're discussing.

MS. MAXWELL: Actually, we can move on to the next one that says long-term hospital.

DR. WILENSKY: Stephanie, my sense then is that people agreed with the recommendation that we just passed over very quickly, which is that we're doing to discharged-based unit of payment.

MS. MAXWELL: Yes.

DR. ROWE: That's what she said.

DR. WILENSKY: But again, I'm just trying to make sure that when -- especially people in the audience who are trying to following our discussion -- are looking at a recommendation that is not matching the discussion.

What is up here now is the recommendation that we are discussing.

MS. MAXWELL: We passed quickly over the discharged-based as well as the MDS-PAC data collection.

DR. ROWE: If you think that we pass quickly over any of this stuff.

DR. WILENSKY: If anyone has any question about the wording or any of the specifics of the discharged-based payment recommendation, we can go back after that. Because we've discussed the concept but I don't know whether anyone had any concern about the wording.

DR. ROWE: But based on what Bill just said, and I may have been misunderstanding who these patients were, but if these are really a different set of patients and if we have not really discussed this in detail here, just because the industry wants a discharge-based payment, there's no reason for us to make a recommendation supporting it.

I mean, I would be more comfortable unless -- while we still have electricity -- to pull it until we really feel that we've discussed it and we have recommendations.

DR. CURRERI: Except that HCFA's recommendation and industry's recommendation are both for discharge unit of payment.

DR. ROWE: That's fine, so we can remain silent.

MS. MAXWELL: No, HCFA is for per diem.

DR. CURRERI: Oh yes, it is per diem.

DR. ROWE: So why should we weigh in if we haven't really thought about it, unless we have and I haven't --

MS. MAXWELL: The patients in long-term hospitals many times have the same diagnoses and principal diagnoses of those in long-term care facilities, as in some patients in rehabilitation facilities and some patients that are more along the lines of the medically complex patients in the SNFs.

And they also get different rehabilitation services, different kinds of therapy. The difference, in part, is the number of comorbidities and the general frailty

of those patients.

DR. CURRERI: There's a lot more intensity of care, you know, monitoring ventilators and so forth to keep them going because if they stop it's not a good thing.

MS. MAXWELL: Right. Part of that is reflected in the length of stay. There, of course, is the 25-day floor in the length of stay for these facilities but the average is at 33 days right now, and the average in rehabilitation facilities, just to give you that comparison, is about 18 or 19.

DR. ROWE: I'm supposed to be a geriatrician here. I just don't have enough information about these patient populations to feel that I have an informed opinion. I appreciate what you're saying.

DR. KEMPER: I suppose that given our sort of list toward episode-based care, that one thing we could say is HCFA should consider both. I mean, that's not much of a recommendation. But it's different from where they are.

DR. ROWE: Our bias would be toward discharge-based, but I just think we have to have a process.

DR. CURRERI: Stephanie, what is the date that

long-term care hospitals become prospective?

MS. MAXWELL: There is no date for moving them to PPS. There is only a requirement in the BBA that HCFA begin the stages of designing and thinking about a system and report to the Congress this October on their efforts.

DR. CURRERI: Because this new per diem methodology that they're looking for, it seems to me it's going to take quite a few years to both collect data and then validate it, then disseminate it and educate people. It doesn't seem, to me, like a reality in a four year period even. Which is why I think we ought to go with FIM-FRG for the rehab SNFs.

I guess there isn't any pressure in this area, since there isn't a specific date.

MR. MacBAIN: Do we then want to recommend to HCFA that in their October report they specifically address the issue of discharge-based payment and either tell us why it's a good idea or tell us why it's a bad idea?

DR. CURRERI: That might be a good idea.

DR. WILENSKY: Right. Any further comments on the recommendations?

MS. MAXWELL: There's one more. Even without any required PPS state for long-term hospitals, when the rehabilitation facilities move onto the PPS, psychiatric facilities will compose over 90 percent of the facilities remaining under the TEFRA system.

Given the shortcomings of the TEFRA system, even after the BBA -- or some providers would say especially after the BBA -- the Commission may want to encourage additional work in the area of patient classification with an eye toward moving, in the future, toward a PPS for these facilities in the future, as I said.

DR. ROWE: Isn't that in the BBA?

MS. MAXWELL: No, it is not. There was efforts in the '80s and '90s, just among various federal agencies to explore classification for these systems. They, at first, reaffirmed the inadequacy of the DRG system as it was implemented for acute care hospitals in these facilities, in large part because there are so few DRGs that the psychiatric patients fall into.

I wanted to give just a little bit of background on what some of the case-mix research on these facilities

have shown. Moving on kind of the DRG-based approach, researchers have found that the patient age, the type of their psychiatric service, and even their marital status had large improvements in classification designs building off of kind of a modified DRG system.

More recently, some researchers are using more detailed patient assessment instruments that frankly look a little bit like the MDS, only modified for these patients. These assessments instruments indeed gather information on the patient's history of mental illness and/or substance abuse and on their prior use of services.

Classification efforts have also found that the practice patterns vary substantially by treatment setting in these facilities and reflect both patient severity and different treatment goals across different settings. For example, the free-standing facilities appear to have a much more severe case-mix than the units.

That's a short summary, but it does collectively indicate that there has been some research in case-mix for these facilities. There hasn't been very much in the last couple of years. Again, this was mainly in the '80s and

early '90s, that what I summarized, had been worked on.

Again, the question is whether or not you would like a recommendation that would support case-mix research in these facilities with an eye toward a PPS or toward more modestly possibly monitoring these facilities under the TEFRA system given the BBA changes to that system and given that they would be the main provider group under it after the rehab facilities go onto the PPS.

Last year we did have a recommendation on these which said -- which backed it down from something like the last sentence here, the last recommendation said that they should investigate classification systems and generally work to improve the payment system for these facilities.

DR. ROWE: I think that there's a big difference between the draft recommendation that's up there and the possible recommendation that's in this package. I think it's an excellent improvement.

MS. MAXWELL: This one?

DR. ROWE: The one that's in the package that we received says the Secretary should investigate further patient classification systems for psychiatric facilities

with an eye toward developing a prospective payment system for the future.

That one says further investigate classification system for the psychiatric patients. I think that this is one of our problems, one of the problems we've been discussing.

If we're going to be consistent about wanting to take care of the same rehab patient, whether they're in the high end of a SNF or the low end of a rehab hospital, it's the same patient who needs the same care, I think -- and I think it helps with Woody's argument, too, and concern about the rehab hospitals, how are they really different if they're separate than being part of a hospital?

If we focus on the patient's needs as opposed to the facility's needs, I think it just makes more sense clinically. So I would prefer what's up there. I just want to point out that is different than what's in the book.

DR. NEWHOUSE: I agree with that. I'd like to go back to the case-based system. I think these patients are, in all the data I've seen, are very heterogeneous and I would suggest we raise the issue of an outlier system for

any case-based system.

You have a paragraph in the text that talks about encouraging inappropriately early discharges and that could be mitigated by a transfer policy. I'm not persuaded -- I think it's an outlier policy we want, not a transfer policy, to address the --

DR. LAVE: Short-stay, long-stay outlier. Low cost, high cost outliers.

DR. NEWHOUSE: Okay. All right.

DR. WILENSKY: I think at least to urge the consideration of an outlier policy. I don't know that we know enough at this stage to specifically recommend it but I think we can recommend the consideration of an outlier policy.

DR. NEWHOUSE: But it ought to be on HCFA's radar screen.

MS. MAXWELL: Some of the prior research in this area that was successful in its r-square is with per-case as the dependent variable regarding these patients, were research efforts that basically used a per-case system up to a certain number of days and then went out with the per

diem. Or it might have been an outlier oriented system after that.

It just reflected, or it took into account the extreme or practically bimodal difference in the length of stay in these facilities and these patients.

DR. CURRERI: But when you say an outlier policy, just to educate me, are you indicating an outlier at the top end and the bottom end? So if we get somebody at a rehab center for one day or two days or something like that?

DR. WILENSKY: I don't think, at this point, we want to specify.

DR. NEWHOUSE: I was thinking of high end, but as Judy says the transfer policy would cover the low end.

DR. CURRERI: That's true.

DR. WILENSKY: Then again, I think right now --

DR. NEWHOUSE: Although I guess it would if you just discharged home with no home health, there's no transfer.

DR. CURRERI: There's no penalty.

MS. MAXWELL: An outlier policy is a part of the BBA elements for the rehabilitation PPS.

DR. NEWHOUSE: But how about the long-term?

MS. MAXWELL: Not stated.

DR. WILENSKY: I think, at this point, our recommendation is that it ought to be considered.

DR. NEWHOUSE: That would be both high end and low end?

DR. LAVE: I think that if you have an average length of stay of 18 days or something, that you might want to think about having a low end outlier in that circumstance.

DR. CURRERI: Because that would get away from having miraculous recoveries in two days.

DR. WILENSKY: Again, I think at this point, until there's further work done, we ought to not be too specific about what we're recommending with regard to an outlier policy.

DR. NEWHOUSE: I think since the PPS outliers are only high end, if we mean to include low end, we need to say that. All we're talking about is being considered.

DR. WILENSKY: Again, as long as we're saying that this is an issue that we ought to --

DR. LAVE: But we should mention...

DR. WILENSKY: Fine. Since again, we're not specifically recommending the outlier. We are asking that it be considered, given the unit of payment.

MS. MAXWELL: Just within the text for both the rehabilitation and the long-term hospital recommendations.

DR. NEWHOUSE: I would have actually liked it in the recommendation, as a recommendation to consider the outliers. I'm not sure it's being considered. You say it's in the BBA for rehab?

MS. MAXWELL: An outlier policy but it doesn't specify short-term, the low end or the high end. I think people generally consider it to refer to the high end.

DR. NEWHOUSE: I would prefer it as a recommendation but if other people don't want it, that's fine.

DR. WILENSKY: I would prefer that be -- we'll be much more specific in this recommendation. I think it should definitely be in the text, but it just seems to be a different level of recommendation.

DR. CURRERI: We probably need some data which

tells us how many of these patients are say two standard deviations away from the mean, or more than two standard, either way.

MS. MAXWELL: We have that and we can put that in.

DR. ROWE: By definition, I can tell you what percent, if it's normally distributed.

DR. WILENSKY: Stephanie, are you comfortable with the revised recommendations?

MS. MAXWELL: Sure. I'll be busy for the next few days.

DR. WILENSKY: We'll look forward to seeing the revisions.

DR. KEMPER: Before we leave that, I get a little concerned about possible effects on quality of the prospective payment changes and I realize this is a report on payment policy, but I'd like to get other people's reaction to putting in here to make clear that it's of concern some kind of recommendation that HCFA should establish a quality monitoring system to be in place as the prospective payment changes are implemented.

It comes up here and it comes up in a couple of

other places, it comes up in the home health as well. I suppose there's a question of is the report coherent if it's really about payment but then you put in things about quality.

MS. MAXWELL: A recommendation of that nature is included in the SNF recommendations. We can have a very similar recommendation in this chapter.

DR. KEMPER: I believe it's not terribly controversial, I guess, except that it takes work.

DR. NEWHOUSE: And money.

DR. KEMPER: And money.

DR. WILENSKY: I also support that recommendation.

DR. ROSS: Something parallel to the SNF recommendation?

DR. WILENSKY: Right.

DR. LAVE: We're making a number of recommendations which increase HCFA's costs. Should there be any statement about that in here, or should we punt on that?

I mean, we're back to the issue of having an underfunded program take on more and more complicated

missions on quality, which lead to probably more importance on the quality monitoring aspects of it. I just wonder whether or not --

DR. WILENSKY: Judy, there is a statement that Joe and I have both signed that's in the introduction of Health Affairs. We can distribute that to the commissioners. If it were of interest, we could --

DR. NEWHOUSE: We should say what the statement says.

DR. WILENSKY: We'll distribute it before --

DR. LAVE: We may want to think about whether we want to make a statement about that.

DR. WILENSKY: Right, and to basically support the same sentiment. We'll distribute it. I can tell you what I think it says, but I'd rather that you read it.

But it is a concern about the fact that HCFA has been given a large number of responsibilities as a result of the Balanced Budget Act without adequate resources to carry out those responsibilities. Irrespective basically of your opinion of how efficiently or effectively HCFA may be operating at any moment in time, the level of additional

responsibilities is not matched by either dollar or personnel ceiling resources.

DR. ROWE: It says something along the lines of HCFA's ability to provide assistance to beneficiaries, monitor the quality of provided services, and protect against fraud and abuse -- a major concern -- has been increasingly compromised by the failure to provide the agency with adequate administrative resources. Even with the addition, et cetera.

And it's signed by Stu Butler, Pat Danson, Bill Gradison, Bob Hounds, Marilyn Moon, Joseph P. Newhouse of Harvard University, Mark Pauly, Martha Phillips, Uwe Reinhardt, Reischauer, Roker, Rather, Schaeffer and Gail.

MR. SHEA: So we're calling for more auditors, is that it?

[Laughter.]

DR. ROWE: That's what it sounds like to me. More of those former drug agents.

But it's not from MedPAC.

DR. LAVE: That's the question that I'm asking. Does MedPAC want to --

DR. NEWHOUSE: Should we take up the theme here?

DR. LAVE: Should we take up the theme here, particularly given a number of our recommendations which, if they were followed, would increase the amount of work in fact that we would be imposing on the agency?

DR. NEWHOUSE: In fact, with the current level of resources, it's guaranteed that they won't be followed. They couldn't possibly do it.

DR. WILENSKY: The reason I raise that is that was carefully crafted, reviewed by about 15 different sets of eyes. One of the things we could do is circulate it and see whether people felt comfortable with this statement as it stands and literally include it.

Or we could ask the MedPAC staff to write a short version of it and we could have that as a recommendation.

DR. ROSS: The recommendation is to the Appropriations Committee?

DR. KEMPER: To the Congress. I mean, I think in general we don't want to get into agency activities, but I do support this. To me it's self-evident.

DR. WILENSKY: We certainly can have a short

version of this. This is a couple of pages.

But because a lot of time was taken to craft it so that it reflected the general issue without some of the specifics of how well you think HCFA may be using monies. One of the issues that comes up that we, for example, this morning have criticized at least implicitly HCFA's use of $1 million or $2 million and doing something that we think won't accomplish what it set out to do, and isn't in the direction it most needs to go and it should redirect its efforts.

One of the reasons I felt comfortable with the statement that's in Health Affairs, is that it steps back and basically says irrespective of how you may feel on some of these specifics, this is an important general point.

So we'll circulate that and we can have a discussion in the afternoon before people leave as to how they want us to proceed with this general thing.

Thank you. Dana?

MS. KELLEY: As you know, the BBA required the Secretary to implement a PPS for services provided in skilled nursing facilities. Today I'm going to ask for your

final approval of six recommendations on ways to improve that new system.

The first recommendation regards the development of a SNF wage index. As you'll recall from last month's meeting, the SNF PPS currently uses the hospital wage index to adjust payments to facilities. This index is probably the best available measure of geographic variation in wage levels, but its use in this payment system may contribute to inequitable Medicare payments across regions.

A previous commission analysis that compared the hospital wage index with a simulated nursing facility wage index suggested that geographic variation in labor prices for nursing facility employees differed from that for hospital employees. To account for these differences, and therefore maintain payment equity across facilities, HCFA should use a wage index developed from SNF wage data.

Should we stop at each one?

DR. WILENSKY: Is there anyone who thinks this is not appropriate for this area, given our earlier statements?

DR. ROWE: Without exception. Way to go.

MS. KELLEY: The next recommendation regards

detecting potential distortions in the base payment rates and correcting them when possible.

In developing the base payment rates, HCFA adjusted facilities costs to remove the effects of differences in wage levels, like we just discussed, and for variations in case-mix. The wage index used was the hospital wage index. The case-mix adjustment was completed using a rough case-mix measure based on the limited diagnoses and therapy charges available on the SNF claims. Because these adjustments were made using less than ideal wage and case-mix indices, the federal payment rates may be higher or lower than the Congress intended and may be somewhat distorted between urban and rural areas.

This recommendation encourages HCFA to improve the accuracy of these base payment rates when better data become available as the system as implemented and as the wage data for SNFs is collected and made into a wage index.

DR. WILENSKY: Any comment and do we have any recommendations with regard to timing or anything more specific?

DR. LAVE: I do have a question about this. The

question that I have is, do we want to talk about distortions in the base payment rate, which sort of sounds like we're going to go all the way back to the beginning? Or do we want to say about establishing a new payment basis when the good data becomes available?

I would prefer to talk about sort of reestablishing the basis, as opposed to correcting distortions in something that we tried to measure five years ago. It's conceptually, really, quite different. It says that when we get good data, we're going to recalculate this. We may not want to set it, but we're not going to try to improve this old number, we're going to try to start with a good one.

I would prefer, personally, to have something like that day say, rather than to detect distortions in the base.

DR. WILENSKY: Would it be to refine the base payment rates?

DR. LAVE: I would say to reestablish the base payment rates, rather than correction or anything.

DR. KEMPER: Recognizing that that has an update in it.

DR. LAVE: Right.

MR. GUTERMAN: Judy, do you mean re-basing at the time or do you mean something that would be budget neutral to the amount that should be --

DR. LAVE: I'd be perfectly willing to make it budget neutral, but -- I mean, if it's going to be budget neutral at the time, then you don't have to do any re-basing.

MR. GUTERMAN: Right. That's the point.

DR. LAVE: If you're going to make it budget neutral, you don't have to re-base.

MR. GUTERMAN: Because the issue isn't with the cost data that went into the base. It's with the adjustments that were used to standardize them.

DR. LAVE: That's correct, but by the time you go on -- there are two issues. One issue has to do with the blending process. By the time they get around to reestablishing this, the blending is going to be mostly finished, and so you don't have to re-correct the individual's hospital stuff.

That's the way that I read this, that one way to

worry about it is that these nursing homes base is probably quite far off, and so that the blending formula is likely to be funny because of that particular problem.

So the issue then is one of by the time they have the data to do this, the phase-in is going to be over. So the question, it strikes me, is do we want to re-base the system, because the national rates may be so far off what the actual costs are? And I would basically argue that you may want to, in fact, look and see what would happen if you wanted to re-base the system, given that you had problems in going in, and that you would reflect on, at that particular period of time, if you were way up or way low because the data issues here, I think, are more severe than they were certainly in PPS. And PPS was pretty bad.

So that would be my recommendation, that we talk about whether or not you wanted to re-base the system or not, depending upon the data. But I don't think you want to go back and do each individual's nursing homes.

DR. WILENSKY: Next recommendation.

MS. KELLEY: The next recommendation regards refinements to the RUG classification system, particularly

related to non-therapy ancillary charges. The discussion here will note that the SNF PPS assumes that the use of non-therapy ancillaries is correlated with skilled nursing time, which is a highly questionable assumption.

Payments, therefore, might not be adequate for patients who need relatively high levels of costly non-therapy ancillary services such as respiratory therapy, lab tests, imaging services, and drugs. As a result, certain types of patients could have trouble gaining access to SNF services.

HCFA is working in this direction and this basically would support their efforts.

DR. LAVE: I had a question about this one, too. Maybe, Jack, you have an idea about this.

I would wonder whether or not, in fact, these other services are more likely to be related to diagnoses and whether that's where they ought to start looking on? I mean, I would think that the drugs that you take and all that kind of stuff would be a function of the diagnoses that you have.

Maybe we ought to just sort of suggest that they

look in that direction as they try to do this, because they haven't.

DR. ROWE: By non-therapy, ancillary charges, could you give us some examples, Dana, of the kinds of things that are included in that so we know what we're talking about?

MS. KELLEY: Sure. It's basically everything except for the room and board, the physical therapy and speech therapy.

DR. CURRERI: And nursing.

MS. KELLEY: And nursing care.

DR. ROWE: Nursing care is not included?

MS. KELLEY: Nursing care is not included in the definition of non-therapy ancillary. So respiratory therapy is a non-therapy ancillary, lab services, drugs --

DR. ROWE: These are non-therapy ancillaries?

MS. KELLEY: These are non-therapy ancillaries.

DR. CURRERI: Radiology.

MS. KELLEY: Radiology would be a non-therapy ancillary.

DR. ROWE: The issue here is there are three

possible determinates. One is just your presence. Second is your functional capacity, how many ADLs you have out.

DR. LAVE: That's going to affect your therapy.

DR. ROWE: And the third is diagnosis. It's a specific disease you have. Those are three ways to look at it.

It sounds to me from this list that we should put non-therapy in quotes, for starters. Because people whose major language is English might read this and think that those entities that didn't have anything to do with therapy, like pharmaceuticals and things like that.

And it sounds to me like it would be diagnosis-related, however there has to be some severity measure. I mean, we've been through this before, but I can give you a list of diagnoses, Judy, history of myocardial infarction, hypertension and diabetes in a 75-year-old man, and you can't tell me whether he's in a nursing home or sitting on the Supreme Court of the United States.

DR. LAVE: But I know these people are in the nursing home.

DR. ROWE: But the severity -- you know, there are

diabetics and then there are diabetics. And so I would not support a diagnosis-related approach that didn't have some measure of severity.

DR. LAVE: We have the ADLs and IADLs actually are used for a lot -- I want to back up.

It just struck me that there was no indication in any of this stuff that people were going to use diagnostic information, and it did seem to me that although it's not very useful for speech therapy and rehab and it's not related to the ADLs and the IADLs, which are related to nursing which they've timed pretty well, that maybe they ought to look at diagnoses.

DR. ROWE: Absolutely. And I think, you know, breaking heart failure patients into history of, mild and severe is likely to have a tremendous impact on describing the kinds of therapy that they're going to get.

MR. MacBAIN: This is a related issue, and this is from a conversation I had with a SNF administrator not too long ago, pointing out that transportation costs were also included in these ancillaries, and that was going to have an impact on admission decisions for patients that had a

significant likelihood of having to be transported back to a hospital OPD for other ancillary services because the cost of the transportation could easily exceed that day's per diem payment.

It's this issue of the relative costs of these ancillaries, relative to the total per diem payment for some of these patients, and it may well exceed -- maybe by many times. It's going to create, I think, a barrier to admissions that's going to have an impact on acute hospital stays and severity issues there, but also on access to skilled nursing facilities.

I really don't think that that's been addressed in enough adequacy. The other question is the volatility of drug prices and what impact that's going to have on either admission or continued stay.

DR. LAVE: I just want to say one comment back about the base statement that I made before, Stuart. And that is that I would not do it budget neutral, partly because we have no idea, when you pull in all these ancillaries and everything, where we really are. So I would certainly definitely not say budget neutral.

DR. ROWE: So what are you going to say, Dana?

DR. LAVE: I'd say when you have better data, when you bring all this stuff together, that they ought to recalculate what the base payment would be and make a judgment about where to set it. In our judgment, it could be higher than where it is or lower, but the data that we currently have to establish the base, when they pull together all these ancillaries, there is a tremendous amount of judgment that was involved.

DR. WILENSKY: But the main point is not to use budget neutrality in the recommendation.

DR. LAVE: Right.

DR. ROWE: I think if we're going to try to be helpful in terms of fleshing out this recommendation or having some additional language with respect to it, I think Bill's point is an excellent one, particularly in rural areas. It seems to me that we should specify that some of the factors to explain variation that should specifically be included are diagnosis, severity, availability of the therapy in the facility, which is another way to get to the transportation issue, and some specific thing so it's not

overlooked.

DR. WILENSKY: In the text.

DR. ROWE: Yes; functional capacity.

DR. NEWHOUSE: But if you say, availability of the facility, you have in mind lowering its payment? So if I put this in I actually get a lower payment? Why would I ever put it in?

DR. CURRERI: No, you'd get a higher payment because you've got to transport the patient to where he can get the therapy.

DR. NEWHOUSE: No, I have to transport the patient if I don't have the thing on the premises.

DR. CURRERI: That's right.

DR. NEWHOUSE: So now if I make a decision to invest and put it in the premises, you're going to ding my rate?

DR. ROWE: No. It sounds like the payment for the transportation is several times less than the cost of the transportation, right? So what we would do is increase the rate, but you'd have to pay for the transportation. So you don't win, it's a pass-through to pay for the

transportation.

MR. MacBAIN: In that particular instance, at least this administrator's view, is what would make sense is make the transportation a pass-through rather than include that as a non-therapy ancillary. Certainly, at least in rural cases, where you don't necessarily want to encourage SNFs to invest in a whole lot of stuff that's there in the local hospital, you'd like to have a patient be able to move back and forth. But now we've created this impediment that one of those two institutions is going to have to pay the transport fee.

DR. WILENSKY: This can be discussion in the text, but this kind of specificity should not be in the recommendation.

DR. ROWE: Right.

MR. MacBAIN: No.

DR. WILENSKY: Any further comments or questions on this recommendation? Next one, please?

MS. KELLEY: The next recommendation addresses the need for HCFA to develop a method for recalibrating the case-mix weights. Over time, these weights should change as

practice patterns, technology, and payment incentives affect the resources used to furnish SNF services. If the weights are not updated periodically, inappropriate financial incentives may develop, as well as payment inequities among providers.

The supporting language will discuss the pros and cons of two options for updating the weights, periodically repeating the staff time measure studies that were used to develop the original weights, and recalibrating the case-mix weights based on the average charges per day in each RUG group.

DR. ROWE: Why did you go from HCFA to the Secretary, and the rest of the recommendations now have Donna developing a method for periodic recalibration.

DR. ROSS: It's going to be the Secretary on most.

DR. ROWE: Is that the way it should be?

DR. KEMPER: Will there be an update process and an update recommendation in future years.

DR. WILENSKY: There undoubtedly will be an update process, but I don't know that we know what it is.

DR. NEWHOUSE: For the weights?

DR. KEMPER: No, I just meant for the SNF payments.

MS. KELLEY: I would assume so.

DR. KEMPER: So one question is whether or not the data are in place to do that, for the commission staff to do the work that needs to be done?

MS. KELLEY: For future years; okay.

DR. WILENSKY: Any further comment? Next one.

MS. KELLEY: The next recommendation regards quality of -- let me rephrase -- regards two issues: that SNFs properly assess patient's needs and assign them to RUGs accurately; and also that they provide the services that patients need.

The report will note that facilities will face strong financial incentives to shift Medicare patients into higher weighted RUGs so as to maximize reimbursement. The RUG assignment is based on some information that is largely under the control of the SNF, so the potential for manipulating RUG assignments will be great.

It will be necessary therefore for HCFA to develop methods to ensure that SNFs are accurately assessing

patients and reporting patients' needs.

Prospective payment also creates incentives for providers to reduce their costs, and this of course has implications for quality. So it will be important to monitor the provision of services to ensure that benes are receiving the appropriate care.

Any comments on that?

DR. CURRERI: I wasn't sure from reading the text how you were going to do these two things, particularly the first one. The cost of going in and auditing each patient four or five times during a stay, because I forgot how many times they have to do a RUG assessment, I can't in my mind visualize that without an enormous expense.

The same is -- the monitoring of provision of services, you have suggested in the text, is primarily one of monitoring access. But I think that it really is monitoring quality of care while in the institution. That's also very difficult.

So in principle I like both of these. I just don't know that they can be carried out. Maybe you can reassure me on that.

MS. KELLEY: Let me address the second one, first.

What we were envisioning at the staff level was perhaps a very gross measure, comparing the services that patient's receive sort of at a base line level in each RUG and tracking that over time to see if there are big changes in the types of services that patients in each RUG receive.

The first, I don't think could be carried out without some sort of auditing process, although there could be a -- the word is escaping me -- the hospitals have a...

DR. NEWHOUSE: PRO?

MS. KELLEY: Thank you; PRO. There could be some sort of PRO function, but I think that it would be sensible for there to be some sort of auditing going on to measure a sample of SNFs. But that, of course, would requiring going in and accessing medical records and that's a big undertaking. There's no question about it.

DR. CURRERI: You correctly point out in here that this is largely a judgment call. Many of these, when you assign people to a various RUG, you are assigning it based on so many minutes of time for this and so many minutes of time for that, and so forth. And a difference of three

minutes this way or that can put them up or down.

MS. KELLEY: Some of it would be able to be monitored on a claims level. A patient can only be in a particular RUG if they're receiving X minutes of therapy. Then the claims could be matched to see that those patients are receiving that therapy. Of course, there would be legitimate reasons why a patient might not, even if they had been assessed up front to need that kind of therapy. There could be flags like that put in at the claim level.

But there's no question this is a big undertaking and a potential big problem.

DR. NEWHOUSE: Isn't the real issue along these lines that when we come to assess the equivalent of the case-mix index change we'll have to decompose coding change and true change?

MS. KELLEY: Sure.

DR. NEWHOUSE: And then the question is how will we distinguish? That's intended as more than a rhetorical question because that's the issue we're actually going to confront downstream.

DR. LAVE: There are a number of states that have

implemented RUG-based classification systems in their Medicaid program. I mean, they use exactly the same system, they use the same data base.

My understanding is that the classification system is built almost exclusively on the MDS. So when the auditing, the current survey and cert process, I think goes in and picks up some of the MDS' and make sure, in fact, that the people are appropriately classified.

So I think that some of that classification system in the MDS stuff, isn't that already in some of the survey and cert stuff?

MS. KELLEY: Yes, and the MDS will also be filed so there could be matching done that way, as well.

DR. LAVE: Yes, but they have to go in and look at a patient.

MS. KELLEY: Yes, absolutely.

DR. LAVE: I mean, they go in and they randomly pull out seven patients and see what's going on.

DR. NEWHOUSE: That sounds like the place to build on.

DR. LAVE: That's where I think we want to build

it on. So I think that, Bill, there's some activity going on that's worried about this.

DR. CURRERI: I'm sure there's ways to do it but I think they're very expensive, if you really want to do it well. What you're really talking about is a very, very small sample to give you some idea of whether there's a system-wide problem.

DR. LAVE: Right.

DR. CURRERI: That can be done, I'm sure. But if you're really looking at facility to facility quality or facility to facility classification --

DR. LAVE: I think the facilities get surveyed every year. You know, there is a huge regulatory process that comes in and surveys these nursing homes every year.

MS. KELLEY: At the state level.

DR. KEMPER: It is state.

DR. LAVE: It is done by the state but they have to go and look at every one of them and Medicaid mandates the MDS on all patients. So one of the things is that there is a state process in place that does look and see --

MS. KELLEY: The text can reflect that.

DR. LAVE: -- whether or not the MDS is being filled up and they pull some of these MDS' and they go and look at the patients.

DR. KEMPER: That's what we should build on, but I think Bill's comments are still valid.

DR. ROWE: The recommendation, I think it's nuts to put this in, this program in place and not have some auditing mechanism. I mean, it's just inappropriate.

But we don't want to make the current regulatory environment even more baroque than it is now. So maybe what we should say is the Secretary should, you know, in cooperation with state agencies or other regulatory agencies, assure some auditing or monitoring. Rather than have the Secretary develop another mechanism, which is not what we necessarily need, right?

DR. NEWHOUSE: The text is going to have to carry this discussion, I think. This is not in the recommendation.

MS. KELLEY: Okay.

DR. CURRERI: I do think it is important to put in the text what state regulations there are, and the extent to

which they're audited.

MS. KELLEY: Okay.

DR. CURRERI: Because I imagine that varies a good bit from state to state.

DR. NEWHOUSE: Dana, are you clear on what you need to do from here?

MS. KELLEY: We have one more recommendation which is not in your mailing materials. It was omitted

The previous recommendation regards patients who are already in SNFs. We also felt that it would be important to talk about patients that might not have access to SNFs at all.

Facilities will face increasing financial pressure under prospective payment and it's not clear what the effects of that will be on the overall supply of SNF services. So we thought that we should include a recommendation that it would be important for HCFA to monitor the impact of prospective payment to ensure that beneficiaries who need SNF care have access to it.

DR. NEWHOUSE: Any issue here? Should this be part of the other monitoring recommendation?

DR. LAVE: I like it separate because it deals with two different patient groups.

DR. NEWHOUSE: Okay. We'll do it.

MS. KELLEY: Thank you.

DR. NEWHOUSE: I think before going on to home health, we should stop and take public comment on what we've done with the exempts and the SNFs, if there is any.

MR. CALMAN: I'm Ed Calman. I'm general counsel to the National Association of Long-Term Hospitals and I only have one comment.

You had a very appropriate discussion about the sample size issue of 2,000. HCFA is proceeding with long-term hospitals with the exact same sample size of 2,000.

DR. NEWHOUSE: As part of the same study?

MR. CALMAN: As part of the same study. They're doing it on long-term hospital patients, 2,000 long-hospital patients, 2,000 rehab patients.

So I would urge you to make some comment on that, in terms of your views, if you think it's appropriate. And then, at some later time, I'd very much look forward to meeting with the Commission to go over long-term hospitals.

We do have a study that's completed by the Lewin Group. Dr. Newhouse reviewed one on the hospitals. We've met with staff and we think it's probably appropriate to spend some more time with the Commission on those issues.

Thank you.

DR. NEWHOUSE: Thank you. Why don't we finish with public comment. We might come back to the study.

MS. ZELLER: My name is Carolyn Zeller. I'm with the Medical Rehabilitation Providers Association, and I want to thank the Commission for its continuing interest and, obviously, active discussion about rehabilitation.

We appreciate the recommendation to move away from the staff time measurement study that HCFA is contemplating and looking more at adopting the RAND research that has previously been conducted using FIM-FRGs as I understand the basis of the final discussion.

We also appreciate the recommendation to adopt the per discharge payment unit, which our industry has supported. The study promoted by HCFA using staff time measurements cannot get to a per discharge payment unit based on its methodology.

We are interested in the proposal regarding the demonstration of Judy's interest in looking at these -- many adjectives were used and I don't recall them all, but we'll call them the higher end, more intense rehab patient that is in the skilled nursing facilities and whether or not FIMs, FRGs can be used for them, as well. We'd be happy to work with the staff perhaps on framing some of the issues in that arena.

So we wanted to thank you again for your interest in this area and always stand ready to provide you any further information. Thank you.

DR. NEWHOUSE: Stephanie, do you want to say anything about the recommendation on the study on the long-term hospitals or do you want to send us something about that later?

MS. MAXWELL: I'll send you something on that later. I know that HCFA is in the process of doing a conceptual comparison between their proposed method of designing a PPS with the proposal that has been designed by the industry. Actually, what I wanted to clarify was the time line of the 2,000 patient study.

I actually had not heard that they had let a contract to have a 2,000 patient study regarding long-term care hospitals, but they definitely were part of the MDS-PAC collection and other similar --

DR. NEWHOUSE: I wasn't doubting that, I just wonder, since we hadn't had any discussion of this in the context of long-term hospitals, whether we were prepared to do that now or whether we wanted to defer that? I think we'll defer it.

MS. MAXWELL: I do have one overhead on the study if you want to discuss it more fully now?

DR. NEWHOUSE: What's the pleasure? Let's spend about five minutes on it and see if we can do it.

MS. MAXWELL: I just have one overhead that summarized some of the elements that Mr. Calman was mentioning in his comments.

Some of the elements of the industry have worked with the Lewin Group consulting firm here in Washington to take two years of the claims and the cost reports data and to look, first of all, at the patients that fall into the long-term hospital setting that fall into just the DRGs that

are part of the acute care DRG PPS. As the second bullet of this slide shows, they use the DRGs just strictly as they were defined in the acute care PPS system. They use those DRGs that have more than 25 long-term hospital patients within them and that resulted in 179 DRGs.

There was a variety of patients that were scattered through several other low volume DRGs. They combined those, arrayed the costs, and created five new DRG groups that basically represent quintiles of costs. After they did that, using the HCRIS and the MedPAR data they basically recalculated the weights for the DRGs using the cover charge and cost structure that comes from the long-term hospital facility patients rather than the PPS patients.

The predictive power of this results in about a .18 if you're looking just at the DRGs. It goes up dramatically if you include an outlier policy.

I know they simulated it with a 5 and a 10 percent outlier policy and I don't remember exactly, I think it gets up into the 30s or 40s, the adjusted r-square, when you add that.

There's also been simulations with DSH and teaching adjustments, basically following some of the same adjustment formats that were put in the BBA regarding the rehabilitation PPS.

DR. NEWHOUSE: But my question was really directed at Ed Calman's comment, which went to the fact that we've had a long discussion actually about the study of 2,000 patients in the context of the rehabs and they were doing a similar thing for the long-terms.

Now my question to you is have you done a similar kind of power analysis for the long-terms?

MS. MAXWELL: No, because in my conversations with HCFA, I actually did not know that they have an immediate plan of a study of 2,000 long-term hospital patients.

DR. NEWHOUSE: So then I think we should probably not comment on that at this point, until we've done some analysis. If you feel differently maybe you could get us something that we could look at by fax or something still in time for this. It could be on the agenda for next year.

MS. MAXWELL: I'll clarify exactly what they plans are. Again, I knew of a conceptual study but I didn't know

that they were going into data collection.

DR. NEWHOUSE: Into the field with a study?

MS. MAXWELL: Right.

DR. ROWE: Just because the end of 2,000 is not appropriate in one study --

DR. NEWHOUSE: That's why I said if we haven't done the analysis, we shouldn't comment.

DR. ROWE: It's a different patient population, as has been pointed out here. We need to see what the power analysis is. I wouldn't assume a priori that 2,000 is the wrong number.

DR. NEWHOUSE: If I had to bet, I'd bet that. I think we should do the analysis.

All right, we're ready for home health.

MS. BUATTI: As you know, the BBA mandated new payment policies for Medicare home health care, including the development of a prospective payment system for home health services, as well as the current interim payment rules. Setting payment rates that create incentives for providers to furnish clinically appropriate high quality care is difficult.

As discussed in chapter one, it's important for payment systems to employ other mechanisms to support the payment rates. Some of these mechanisms are addressed in the chapter on home health.

I'd like to go through these in this order, yielding for commissioner comments as we go along.

Current home health eligibility coverage and guidelines are broad and difficult to enforce. An individual may qualify for the home health benefit if he or she is confined to the home and in need of skilled care as certified by a physician. Once eligible to receive the home health care, a beneficiary may receive an unlimited number of services.

As discussed last month and in the paper, the Secretary is required to submit a report to the Congress on the requirement for the home bound requirement and develop normative standards for home health claims denials. These are important first steps in defining the home health benefit.

While it's too early to comment on the guidelines specifically, it is likely that any guidelines will be

difficult to enforce without a legislative authority.

DR. CURRERI: Does that need to be in the recommendation, about the legislative authority? Because what I got from the text is if they just establish coverage then eligibility guidelines are going to be challenged in court almost immediately again.

DR. WILENSKY: I think that asking for clarification in the statutory language will not prevent judicial challenge necessarily, but we are clearly in a position -- it appears that the current statutory language has not allowed a regulatory structure to develop that seems consistent or appropriate with at least the agency's interpretation of the statute.

So it does seem that a different statutory language, however the Congress wants to write it, would be helpful unless they feel that the existing language, in fact, is to their liking.

You're not going to get beyond where you are without at least new statutory language. And when the regulations are developed around that, they undoubtedly will get challenged in some way, or it would not be surprising if

they're challenged in some way, since that is frequently the case with HCFA regulations.

I think this is a reasonable recommendation. I don't think we ought to fool ourselves that when the regulations are issued that there might not be challenges. I would support this recommendation.

DR. CURRERI: So this is really a Congressional recommendation.

DR. WILENSKY: Definitely. It's definitely a Congressional recommendation, not a recommendation to the Secretary. One less thing for the Secretary to do, for the moment.

MS. BUATTI: I guess we'll to move on to the next recommendation.

Although physicians are technically required to certify medical necessity for home care, decisions about that care are made by the provider subject to Medicare rules. An independent assessment of need, made in consultation with the physician, could help to ensure that appropriate levels and types of services are provided, consistent with the needs of the patient.

I reviewed the transcript from the December 1997 meeting when this idea was first introduced, to try to get a sense of the Commission's original intent. From that I gathered that the Commission recommended Medicare employ an individual to work with the physician to establish a plan of care that meets the patient's needs, rather than an auditor who would review claims after the services are provided.

On the note of the audit function, I believe this will be accomplished through the fiscal intermediaries once the normative standards for claims denials are established. As I mention in the paper, HCFA recently awarded a two-year contract to develop these standards. So in any case, that would be a little ways down the road.

At the last meeting, at least one commissioner inquired about how other payers use coordinated care techniques in a fee-for-service setting. According to an AHCPR study that reviewed characteristics of different home health benefits, most Medicaid programs and other state programs employ case managers directly to help determine the type and the number of benefits received.

Related to this, HCFA is required by the BBA to

conduct a demonstration project that uses coordinated care techniques in Medicare fee-for-service. Right now the agency is planning a disease management demonstration, so presumably some of the issues that were raised by the Commission last time about how this would work, or how it could be implemented, could be addressed in a demonstration project.

DR. CURRERI: I'm all for this recommendation, but I wonder if we want to say for extended periods, because as I remember the data that you presented to us, there is a natural point at about six months of those that were still on home health at six months were likely to be on for a year or more. And those less than six months were usually only on for three or four weeks, if I remember the data correctly.

I'm just a little worried about saying for extended periods because somebody might interpret that as five years or 10 years or something like that. I think we should, if it's possible and justifiable with the data, say such as six months or something of that sort.

DR. ROWE: Didn't we talk about a number of

visits?

DR. WILENSKY: I thought we talked about 60 visits last year. Was that not correct?

MS. BUATTI: I think that did come up. I reviewed an analysis I did last year on home health utilization and close to two-thirds of beneficiaries received fewer than 60 visits in 1996. I didn't check the percentage for 60, but that will give you a sense.

DR. WILENSKY: That would seem like a reasonable cut-off.

DR. ROWE: I think the number of visits is maybe a better measure than the number of days that they're on home care because it's the care that we want to be looking at, rather than the calendar.

DR. WILENSKY: Right.

MS. BUATTI: Would the Commission feel the same way under a prospective payment system that uses an episode-based method for payment?

MR. MacBAIN: If you had outliers.

MS. BUATTI: The other thing is I wanted to know whether or not this should be in a recommendation or not, is

the idea of testing the mechanics of this in a demonstration, or if we should just say that it's a good idea? If you wanted to say that.

DR. NEWHOUSE: With episode you worry about people not getting services. Well, maybe not.

MR. MacBAIN: You made one point in your presentation now that I think needs to be reinforced and that's what we're talking about here is a prospective assessment, not a retrospective.

And the other thing, you asked about an episode payment basis, if there's a payment per case, assuming a certain length of stay, sort of a DRG model. Presumably you wouldn't need to have some outside assessment, that would be handled some other way because the incentive is already there.

If it fit at all, it would probably fit in the context of some sort of an outlier assessment, so that if an agency were applying for additional payments for outlier days.

MS. ROSENBLATT: I'm comfortable with the recommendation, but uncomfortable with the payment. I know

we raised that at the last commission meeting. You have the narrative, but I just can't get over this block of how do you actually do it.

I'm just feeling like we need something stronger there, or some hint of how you would actually get payment in. I don't know if there are other models for something like that within the entire system. The models I'm familiar with in a health care system or in an insurance company don't work for Medicare. So I don't have any past background to rely upon for how you actually -- who do you pay and how do you get the payment out there?

MS. BUATTI: Again, this is one of the things that I thought could be addressed through a demonstration, where someone has spent more time thinking about it than I've been able to devote to this issue.

DR. WILENSKY: But I think this is a separate payment and it's main characteristic is that you pay somebody who is not financially related to the home care agency.

DR. NEWHOUSE: But there is an issue about what that person's incentives are and how they report.

DR. CURRERI: I don't look at it as much different than setting up a case manager that's triggered at a certain period of time.

DR. WILENSKY: Right.

DR. CURRERI: And that happens all the time in certain health plans, at least many of those I'm familiar with in Florida.

MS. ROSENBLATT: That's my point, Bill. In health plans, the case managers become part of the administrative expense. You don't have that here. You're not going to pay the people that administer Medicare to do this.

DR. CURRERI: You could go through the carriers, it seems to me, through the carriers. They could be part of the --

MS. ROSENBLATT: I wouldn't want to see a recommendation from us that it should be through the carriers, because what's going on in with the carriers who are doing the intermediary work is their funding is being cut back, back, back. So you'd be asking them to do more for less funding.

DR. LAVE: I think that there are two issues we

have to talk about, one of which is sort of -- when we started this we were really concerned about the fact that there was an open-ended financing system, which I think that that concern goes away a little bit with the implementation of the limited base systems and the prospective payment systems that we have currently in place.

So I guess the next issue is -- at least I read the incentives in that particular way. So that some of the incentives for continuous care have disappeared. On the other hand, at this point, now you have the incentives for skimping on care. So I think that we still have to be concerned about this issue, although from another direction.

There are agencies out there whom HCFA could, in fact, contract with who often perform case management functions. These are the area-wide agencies on aging. Maybe what we should do is support the demonstration. But I think that the area-wide agencies on aging, where I believe they have them in most states, they perform case management functions for other agencies. They could work with HCFA on this to perform this function.

So I think there is a way that one could do it. I

agree with you, it would be another one of these recommendations that would have an explicit cost associated with it. But it would allow HCFA to begin to move or to think about moving into the directions for quality control and monitoring, which are similar to the types of things that the plans are doing. I think we've all worried about how to do that, and this is another case about how to do that.

DR. KEMPER: They're also private firms.

DR. LEWERS: Just to support this, and particularly if we're going to do the individual, that second portion of that, the HHS IG last week has issued a fraud alert on this very issue, reminding physicians of their requirement ever 62 days and that that requirement does -- to go to one of the points that you make here, that they frequently haven't examined -- that they have to do that. They have to know the condition. So there has been some on this.

So I think that if we do this on a time period, as we've talked about, it would certainly be appropriate and this would certainly be a major step forward for physicians.

DR. KEMPER: I guess I'm not clear -- maybe I should go back and read the transcript myself. I'm not quite sure what we're asking for here because I think it has a mix of audit and additional service. And it's not clear to me how it works.

If it's more driving from the concern of too many services; A, that's fine under the current system but how does that play out once there's a prospective payment system in place, particularly if it's a per episode system? How does this interface with that system? I think we should be looking ahead to that.

DR. CURRERI: There are two ways it could. If it's a per diem system, it obviously would have an effect. And if it's a per episode visit, it's just like Bill said, it would be just for the outliers. And there are going to be outliers. I mean, there are people that are truly going to get 250 treatments of home health care every year, regardless of what the incentives are.

DR. KEMPER: But is that something -- if it's a per episode -- you're saying it's an outlier case that doesn't fall --

DR. CURRERI: Doesn't fall into prospective payment. There would be a different mechanism.

DR. KEMPER: But then it seems to me, if that's the thrust of it, then the recommendation ought to be to incorporate this into --

DR. NEWHOUSE: It's got to take cognizance of the financial incentives.

DR. KEMPER: That's true, too. But it also needs to be incorporated in the prospective payment planning. It's part of a system that would be established with the prospective payment.

It's also the case that I guess I wonder how this works in combination with the physician. I mean, if it's a nurse assessor being paid by Medicare to go talk to Ted about his reauthorization, where he thought there should be an additional 60 days but the nurse assessor said no, this patient's just fine with out, how does that all sort out? I mean, this says consult but what does that mean?

So I guess I'm inclined to back off the firmness of the recommendation, maybe even go with some experimentation, to really understand exactly what it is

we're thinking about here. It doesn't seem that we've given it quite enough thought.

DR. CURRERI: Could I just respond to that?

One of the things is these people have to be homebound. When you think about that, and the extra costs of copayments, the likelihood of the physician examining this patient every 60 days is nil, particularly if they've had 250 treatments in a year, and most of them are for helping with daily activities of one sort or another.

So unless you have somebody that's going to go out into that home and find out whether they continually need these services, or need more services for that matter, I don't think it's going to get done by the physician. Ted, you may disagree with me, but I don't think it's practical.

DR. LEWERS: I think that if you read the IG's fraud alert, it's going to have to be done. I don't think there's any question about it. And if you've read the definition of homebound, that leaves a lot to be desired. There are a lot of holes in that.

DR. WILENSKY: They're obviously not homebound by what --

DR. LEWERS: They're not homebound.

DR. CURRERI: Otherwise, you're going to be making a lot of home visits, is what I'm saying.

DR. LEWERS: That's right. That doesn't fit. And to answer Peter, where does the responsibility lie? The responsibility lies with the physician signing the cert. The physician has to sign the cert and the physician has to know that that patient needs that service or else you've got a problem with fraud and abuse of the system.

That is what the IG is cracking down on and this is a very strongly worded alert that has come out, and the IG has done something a little different on this occasion. They have sent it camera ready to every medical society and every specialty society in the country. We, the AMA, are going to be focusing on this. It's going to be a major publication because this is a major problem that has existed.

So I think that yes, Bill, they're going to have to do it or they're going to be in serious trouble.

DR. ROWE: What's the problem? What do you think the problem is, Ted?

DR. LEWERS: The major problem has been that the majority of physicians do sign them and do sign them appropriately but there has been abuse recently, and one example that the IG gave to me when I actually met with her on this, was that they had an example of a physician being forced because of employment to sign 800 certs in a very short period of time, never having seen the patient.

So they are really going to crack down. The IG does point out that for the first time basically pointing out that the majority of physicians are not involved in this. But because of what has been happening, there is going to be an increased scrutiny of the certs and certs being signed in advance are not going to be accepted. So there's going to be this point, there have been problems with this.

DR. WILENSKY: I thought the other issue that we hoped a case manager, presumably a geriatrically trained nurse practitioner or some similar person, would provide is that they would allow physicians a better ability to stop home care in cases where that was regarded as appropriate but where there was a lot of pressure from the family on the

physician to continue because it was not at a cost to either the physician or the family member. And that to do so in a way that we thought would make clinically appropriate home care available but to provide for some additional support in this area.

And as a result of having it serve that function, it would seem to me that suggesting this, if we still support it, is appropriate because at this stage we don't know whether prospective payment is going to be per diem or per case. But in either situation, it's likely to be a while.

So it would seem to me that to suggest this, either on a limited basis in maybe a couple of states if you're uncomfortable to propose it on a full basis, is something that seems appropriate because the issue of the distribution of very high number of visits by some numbers of individuals, and particularly with the pressure from the inspector general's office on physicians, that having an individual with expertise in this area provide an assessment after 50 or 60 visits would be helpful, both to the physician and to the patient.

DR. CURRERI: As I recall, this is only 5 percent of the entire home health care --

DR. WILENSKY: A small number of where all the money is, as frequently happens.

MS. BUATTI: I like to add one thing to that. We've heard some anecdotes to suggest that physicians are feeling some reluctance to prescribe home health services because of the additional requirements placed on them by the BBA. In addition to the signature they are required to provide their provider number, which of course makes tracking and auditing and prosecuting much easier.

So it's possible that under the current payment system in some areas the stinting issue that Judy raised with respect to prospective payment might also be a concern now. So the independent assessment could provide the physician with a greater level of confidence about the need for care to go both ways.

DR. LEWERS: There's no question that there is a potential access problem with this, but quite frankly physicians have not been aware of all of the requirements. They've never been published -- they're published in spots

that physicians practicing medicine would not read and would not have any access to that material. That's why the IG has taken this step forward, to ask the states and the specialty societies for publication of this information, because of that very problem of access. It's a serious problem.

DR. NEWHOUSE: I think Peter's question still is unanswered, and there's actually -- as I try to look at the problem, we have had and continue to have the physician as a gatekeeper for these services. There's a lot of feeling that there's a lot of problems with a physician as gatekeeper for all the reasons that have been discussed.

And now we're talking about well, maybe we should have the nurse or AOA, agency on aging, or whatever, be a gatekeeper.

DR. CURRERI: A co-gatekeeper.

DR. NEWHOUSE: Another gatekeeper. And at a minimum, that raises the question that Peter raises of what happens if these two gatekeepers conflict in their recommendations? What next?

I haven't heard an answer to that question. I'm kind of -- you know, I think this is ultimately about a

gatekeeper type function, although in both a positive way and a negative way.

The way it's set up the physician is partly an agent for the patient, or we intend for the physician to be an agent for the patient. The nurse that we're setting up here is sort of like an agent for Medicare. So it's not so inconceivable that they would conflict. And then what? I don't know.

DR. KEMPER: If they never conflict, then there's no effect.

DR. LEWERS: They will, but according to the regulations, the medical necessity and the cert, which is required, is the physician's responsibility and the physician is going to have to work out the conflict before signing that cert. It's a very simple fact.

DR. WILENSKY: At least under current law.

DR. LEWERS: That's where the buck stops.

DR. CURRERI: I think if there is a conflict, there is an opportunity for the patient to be seen by both people together and work the conflict out. I mean, that's the way you usually work those conflicts out. And it may be

that the person who is representing Medicare missed something or the doctor missed something.

I'm not worried about a --

DR. NEWHOUSE: But there's such vague standards.

DR. ROWE: I think that we have to look at how it works in the real world. I'm not trying to put myself up as an example of somebody with a large home care practice, but I have one patient on home care currently. I must talk with the nurse once or twice a week about the patient. And last week the nurse wanted to do X or was concerned about Y and I didn't think so. So I went to see the patient.

I mean, what happens if you have a conflict is the doctor then goes and does a visit. As long as the doctor and the nurse are communicating and things are making sense, fine. And when they don't make sense, then the physician goes and makes an evaluation and they reconcile it. I mean, that's how you do it, right? That's the real world.

MR. MacBAIN: I agree with that. If there's a conflict, the physician is the one who's making the final decision. That's whose patient it is. If you have a persistent pattern of that, where a physician is continually

overruling determinations made by a particular agency or particular nurse in a particular agency, then either the agency has to deal with that or at some point they may both be explaining to the IG what's going on.

But we could create this enormous pyramid of the hierarchy of appeal processes that would be ridiculous. And ultimately the responsibility still belongs to the physician whose patient this is.

DR. LAVE: Since this was something that I felt very strongly about at one time, and I'm now totally confused about it, I'm wondering whether or not we might want to basically modify this a little.

First of all, Jack, I would say that your relationship with your one home care patient is not typical from what we have heard about home care patients in general.

DR. ROWE: Is that because of the quality of the physician?

DR. LAVE: Yes, definitely.

DR. ROWE: He's an outlier but we won't say in which direction.

DR. LAVE: That's because you're an outlier. I

mean, there are physicians like you in the world, that's why we consult with you.

I think that our main concern, when we started all of this, was the fact that we had all these people with all these visits, that there really was no sort of independent assessor of what was going on, that we knew from the physicians who we had talked to that they really had extraordinary little interaction with these patients, and that somebody would suggest that the care be extended and the physician would sign off on it. That seems to have been the state of the world that was present then.

So in that state of the world, having somebody go in and assess and monitor the patient made a lot of sense, at least to me, to think about it.

We now change the state of the world considerably. The state of the world is now a limited world where the fears are just exactly the opposite from what we really had in mind before. I hate to have us back off what we have here because I think it's terribly important.

DR. CURRERI: Excuse me, how has the world changed?

DR. LAVE: The world has changed because of instead of having a payment system whereby people on home health who provided home health services were paid for each visit, there are now limits. And there is a per beneficiary limit in terms of what goes on.

So that if, in fact, one has beneficiaries with very long stays then, in fact, the agency can bump up against its limit and its payment rates would go down. So that's where the incentives for these long stays that we were concerned about, in fact, have decreased.

So I think that under a limit based system -- well, certainly under an episode per case system, one has to be very concerned about stinting. And under a limit based system you have to be concerned about the care provided to very long stay patients. I don't know about the medium one.

I'm not quite sure where that all leads me about how to think about this person because I think it's a different function that we were thinking about in one world than in the other world. So maybe what we should do is not worry about how it would all work but basically -- can you think of a recommendation, Peter, that would get us

somewhere?

DR. KEMPER: I guess it seems to me, the watered-down recommendation is to consider this as part of the prospective payment system, along with other efforts to provide appropriate care for patients who need large numbers of visits.

I understood at one point there was some discussion, and maybe it's still there, about the long stay home health patients somehow being treated differently under prospective payment than the shorter length of stay ones. Well, this could fit into that.

My feeling is it's just not well enough thought out as to exactly how this would work, because there's already somebody doing an assessment. It's the nurse at the home health agency who Jack is talking to, has already done an assessment of needs and so on. And there's already somebody signing the authorizations.

So are they not doing their jobs appropriately?

DR. LAVE: I think the answer we thought was yes, given that the other data that we had was the IG data that suggested that about 30 percent of the visits were

fraudulent, or waste abuse, I think.

DR. KEMPER: But then when you see it down in black and white, what we're really proposing is paying another nurse like the one Jack's already talking to to go out and make another judgment and call Jack and say you know, you guys have --

DR. ROWE: At some point in time.

DR. KEMPER: Yes, at some point after so many visits, you guys are doing it wrong. And Jack will say I'm sorry, I don't agree with you, and he'll sign --

DR. CURRERI: I really disagree with that. I think that most physicians would love to have somebody independent go out there, when the nursing home is putting pressure and the family is putting pressure, absolutely love to have an independent assessment. That's number one.

Number two, I think you have to separate out -- we keep mixing prospective payment systems with the current system. And as near as I can see, although there have been changes in the current system, it's not altogether clear to me on a patient by patient basis that these unnecessary long term home care will necessarily be bumped out, and those

that need long care stay in the system, because they could be different -- different agencies could treat it differently because it's an institutional cap, not a single patient cap.

If you have a prospective system, I agree with you, and I think we've talked about that, is that you would have a per-case episode if you wish for everything except that 5 percent of the patients that have 60 visits or more, for perhaps valid reason, and they might be in some other system like an outlier system or something of that sort.

I think what Gail said is very important. If you think that prospective payment is going to be easily -- I mean, I'm sure there will be a transition period and so forth. It's going to take a long time before you have pure prospective payment.

DR. WILENSKY: What Bill Curreri has said reflects what physicians have told me over the past several years, that having someone come in to provide an assessment about the need for clinically appropriate home care visits would be of assistance because it's a tremendous pressure that can put on physicians with regard to additional home care

because it doesn't cost either the physician or the patient additional money.

As our recall our discussion, it was partly in response to having heard this said by physicians of the pressure on them, but it was also as much in response to trying to see that seniors got clinically appropriate home care, recognizing that this is a special area, and that for relatively short term home care visits it probably wasn't worth the additional cost of having somebody go out to look at the clinical need.

But once you started getting into long term users of home care, it was as much to help the physician, but also equally to try to increase the likelihood that patients were getting clinically home care.

DR. LAVE: Then I recommend we stick with this draft recommendation.

DR. WILENSKY: I felt strongly before. I continue to feel strongly this is a good addition, but with caveats about if prospective payment were to move to a per-discharge, that would affect the role that such a reviewer or assessor would play. But I don't see if any time in the

near term.

DR. CURRERI: Maybe we ought to say, in the interim, prior to establishment of a per-episode case that we suggest -- that's too awkward. Forget that.

[Laughter.]

DR. LAVE: Do we want to make suggestions in the text about possible ways that this could be done. We've mentioned the area-wide agency, and Peter has mentioned alternative forms. So that there is some information there at least that we've thought more about it than just waved our hands.

DR. CURRERI: I think every state has an area-wide agency now.

DR. LEWERS: Are we going to determine a time certain to define extended --

DR. LAVE: 60 visits.

DR. NEWHOUSE: I think we suggest the number of visits.

DR. CURRERI: I think we should do that.

DR. ROWE: I think the number of visits is a more clinically-based approach than number of days.

DR. LEWERS: Right. Just wanted to make sure.

DR. CURRERI: Because the potential is there for somebody in 90 days getting 60 visits and that probably ought to raise a flag that maybe that patient isn't in the right environment.

DR. LEWERS: I agree.

DR. WILENSKY: Next recommendation?

MS. BUATTI: Home health agency bills do not describe the services that are actually furnished by the agency. By providing information about the services purchased through standardized coding, Medicare would be better able to monitor quality of care as well as compare services across home health agencies and over time.

The only thing I have to add to this, last month there was an issue raised by some of the commissioners about the quality of the information HCFA would receive back if payment were not dependent on the codes recorded. I believe a similar situation exists in the managed care world, and the BBA addressed this issue by requiring attestation by CEOs of the health plans to the accuracy of the data.

If the Commission feels that they would still like

to make this recommendation, a similar requirement could be added to sort of strengthen it.

DR. WILENSKY: Any question or comment about this?

MS. NEWPORT: I would just caution that attestations are difficult for CEOs when they have to report or attest under fraud and abuse of 100 percent accuracy. I think if it's a good faith attestation, that they have processes in place to do this as accurately as possible is better. Because that's really the issue with attestation is it's not -- it's holding people to fraud and abuse standards that are a problem.

DR. WILENSKY: What does this have to do with the attestation?

MS. NEWPORT: She just asked -- I'm just saying that administratively it's fine. It just has to be carefully worded -- what it says.

DR. WILENSKY: Is that not what --

MS. BUATTI: I didn't have any discussion about attestation in the paper. After I sent you the papers I had some thoughts about --

DR. WILENSKY: Okay, thank you.

The next recommendation, please?

MS. BUATTI: I think the Commission has spent a fair amount of time discussing this issue but at different times, different preferences have been expressed. I really don't have anything new to add to what's already been brought up.

MS. JACKSON: I know I was here when that recommendation was made. Since then I probably have had some thoughts about it. The patients who have services from home health agencies are usually older, they're sicker, and they're poor -- poorer than other Medicare beneficiaries. They already pay a large part of their medical bills such as for drugs and some of the other services such as for physician fees.

I think that a copay, even if it's a small one, would impose a burden on these individuals. But now I have mixed emotions since we've sat here and talked about the home visits. I don't really know at this point, but I do believe that for most of those individuals that we should not have a copay for them.

DR. MYERS: Does our recommendation have to imply

that the copay is across the board for all patients irrespective of financial circumstances? Or could it reflect some concern regarding those patients that are in those circumstances?

DR. ROSS: You can think both about differences among patients as well as differences among whether it's prospective payment, whether it's discharge-based, per diem.

DR. NEWHOUSE: The Medicaid patients would presumably be exempt.

DR. WILENSKY: Yes, presumably anybody who was on either Medicaid, QMB, SLIMB, any of the definitions, because they're readily available, which takes it --

DR. NEWHOUSE: Not SLIMB.

DR. WILENSKY: Doesn't that take it to about 130 percent of the poverty line; is that correct.

DR. NEWHOUSE: But it doesn't exempt the copays.

DR. WILENSKY: But we could.

DR. NEWHOUSE: We could, yes.

DR. WILENSKY: No, I'm saying that any existing program would be an easy definition to use to exempt lower income. So we could, if we wish, say that this copayment

should not affect individuals on Medicaid -- there's not much point -- or the QMB, or the slightly higher income, the SLIMB or whatever it's called. So that would at least knock off the -- I don't know whether it's 130 to 150 percent of the poverty line seniors would by definition not be included.

MR. MacBAIN: As I recall when we first started talking about this back in the ProPAC days, the intent was to create a transaction that would bring to the attention of the patient or the patient's family that these visits were occurring and serve as a check for someone to say, wait a minute, this is enough, we really don't need any more of these visits. We don't want to pay out any more of this money.

But if we take a look at who it's going to affect, it's not going to have any direct effect on people who have Medicare supplemental coverage. It will appear somewhere out there in the premiums, but it won't have that impact as a check on additional visits. Nor will it on Medicaid, nor will it in the current context on the next tier of poor people.

DR. CURRERI: Can I ask you, Medicare supplemental contracts don't include home health care.

MR. MacBAIN: They don't right now. I'm making an assumption. But it would be very unusual for them to not. I think that given that the purpose of supplemental coverage is to cover the copays and deductibles, and it may include some additional benefits as well.

DR. NEWHOUSE: It would require rewriting OBRA 90 to do it.

DR. CURRERI: Yes, and if it's small they may not want to fool with it.

MR. MacBAIN: That's true.

DR. CURRERI: Let's say it's $400 or $300 total capped, they're not going to fool with that.

MR. MacBAIN: And that could give it some -- if my assumption is wrong then it does sort of leave that group out there as exposed. Then the question is whether it's significant.

DR. WILENSKY: Again, the argument that was raised last year was to put a maximum liability on so that you limit the amount of dollars that people had at risk, and

that you made it modest, and if you wanted to exempt people. The question, at present I think the legislation does not offer A through J options in the Medigap that would in fact allow coverage. Now whether that would continue, I don't know.

It was a controversial decision, so I don't know whether we have some indication about whether or not there is strong opposition -- two of our members, unfortunately, aren't here -- or whether --

DR. LAVE: Gerry was strongly opposed.

DR. WILENSKY: And I assume he would be.

DR. CURRERI: I have no problem in protecting the poor, and maybe even partially protecting those that have no Medigap insurance, because I assume that they're going to have to pay a lot of copayments for other things, their hospitalizations and so forth. But I don't know if it belongs in the recommendations. It seems to me those are details that are worked out and we're really expressing a principle here. To me, it seems like that. And the actual mechanics of it, HCFA or somebody else can work out and still protect the beneficiary.

DR. WILENSKY: I don't want to bias it one way or the other way. I would like to get a show of people who continue either to support it or to oppose it, just so I have an idea about the numbers. Kind of a show of people who --

DR. ROWE: Could we have a little thought about -- I'd like to hear what the priority or hierarchy is of the reasons why we would be doing it. I've heard several reasons. One is to reduce unneeded visits because -- if people have to have a copay. Another is to reduce fraud and abuse by informing beneficiaries that Medicare is being billed for services they may not feel were provided. That's another.

MR. MacBAIN: Assuming that shows up on the bill. I'm not sure that imposing a copay -- it depends. If it's a percentage copay I suppose that would require some detail on the bill. Otherwise they might get a bill for $5, which would have nothing to do with what items or service were actually provided.

So the question is, for the population that will be affected by this, and assuming that it's people who can

afford to pay it.

DR. ROWE: Right, assume it will protect the ones Anne is talking about.

MR. MacBAIN: You know, above some level. Is it then an effective way of trying to achieve what we're also trying to achieve with the case manager? Or are we trying to attack some other stratum in there, and is it worth the added cost? I don't know how to answer that. There is a significant cost to it.

DR. ROWE: Gail, you've been the HCFA administrator. What do you think?

DR. WILENSKY: There is a cost. It is one of the very few areas in Medicare that does not have -- I mean, it is distinct in its lack of a coinsurance. In general, the services that are provided -- I think we are picking up some of the fraud alert activity with the case manager, although obviously only for those that are after 50 visits.

So I think it is a combination of, might it affect utilization in an appropriate way or an inappropriate way for people, both under and over? Because again, at the 50 it will be, yes, there is some sort of a clinically

appropriate pattern in the future. It is different from having some copay, although the cap that we were talking about, a couple hundred dollars, indicated our intent that this would really be more for the first -- by the time you got to having I guess a needs assessment you would --

DR. LONG: It would sort of complement the --

DR. WILENSKY: This is really the under part.

DR. LONG: Yes, this would be the short end and that would be the long end.

DR. WILENSKY: Right.

MR. MacBAIN: Just to answer Gail's question as were trying to go around the table, I've been opposed to this since we first started talking about it at ProPAC. My opposition was based on concern that it was going to fall disproportionately on those least able to pay it. If we're able to deal with that by using some sort of economic guide that's easier than needs testing, then I'm not so opposed.

DR. NEWHOUSE: I supported the copay actually for both of the reasons, although I emphasize more the fraud reason. I would say for the fraud, the image you should have in your head is not the home health agency that you are

all used to dealing with. It's the hit and run person who's setting up a mail drop to collect some checks, that has nothing to do with a legitimate provider.

DR. ROWE: Just sends in bills?

DR. NEWHOUSE: Sends in bills, collects the money, and takes it to the bank and goes home.

DR. WILENSKY: We can either continue going around or --

MS. BUATTI: In response to that, home health users are now being notified as part of a summary notice of Medicare services being billed, of the provision of home care. Now whether or not a beneficiary would be more inclined to report fraud if in fact they owe someone some money, as opposed to just being notified that Medicare paid for a service is, I guess, up for debate.

DR. NEWHOUSE: I think notification will work for some, but if you had to pay $5 you'd pay more attention.

DR. WILENSKY: We do know from other Medicare experience that seniors are usually our best source of information about potential fraud even when they don't. So I agree with Joe's statement, there definitely will be some

notification of HCFA about the fraudulent billing, even if an individual does not have any financial liability. But my presumption is there will be more reporting if they do.

MS. ROSENBLATT: I'm struggling within myself on this one because general insurance principles would say to me that any type of benefit should have some cost sharing in a fee-for-service system because you need the beneficiary watching over it and having some financial liability. So that's the plus side in my mind.

The minus side in my mind is that if you make it small enough to deal with the affordability issue, you get into a situation where the administrative costs of collecting the money may overwhelm the actual amount of money you collect. So I'm concerned about that.

I guess I also, when we're talking about something like collecting a daily copay, that maybe if we're truly going to move to a prospective payment system, having some cost sharing there, it would just be easier to administer. So a possible modification might be to introduce cost sharing at a time when you move to prospective --

DR. WILENSKY: You're using prospective payment in

your way, but not our way.

MS. ROSENBLATT: Okay.

DR. WILENSKY: It is absolutely possible, and I would say without any particular knowledge on this, at least as likely, because of the difficulty in defining an episode for home care, that home care prospective payment will always be per diem.

MS. ROSENBLATT: Thank you.

DR. WILENSKY: I mean, I don't know that, but you certainly have to allow that as a possibility, that we will have prospective payment but it will not be case-based or episode-based payment.

MS. ROSENBLATT: Okay. If you push me then to weigh what I just said, the plus and the minus, I'm probably still on the side of the basic insurance principle of do it.

DR. WILENSKY: Woody?

DR. MYERS: I'm opposed to the recommendation in its current form. I think if we can modify it to exclude those populations that were listed such that it was clear that our intent was not to penalize those that didn't have the funds, in the name of looking for broad principle that I

do support, then I would change my opinion.

DR. LEWERS: I was under the assumption we were going to do the exclusion, and under that basis I support it.

DR. KEMPER: I guess two things have changed since we last looked at it, at least in my mind. One is the notification to the patients, and I know that was a very strong theme in the discussion. The other is the prospect of prospective payment, which I guess I had a different expectation than Gail's, in part because of the demonstrations that are going on. So I guess with that in mind as a different tool to limited expenditures, I would be opposed to the recommendation, at least until we see how that sorts out.

I would be more receptive to something if it is episode-based and there is a long stay case, to rethinking it at that point for the very long cases.

MS. NEWPORT: In managed care, nominal copays are designed not to be punitive but rather to look at appropriateness of service, et cetera, and it's an insurance concept. So cost sharing is something that I'm comfortable

with and I think it can be done, if it is structured in a way that is more to the goal that we're trying to achieve as opposed to being punitive.

DR. LAVE: I would be in favor of a small copayment, and my copayment is actually around $5. I think that's about the size that I would do it. If under a system that paid either a per diem prospective payment system or the current system. I think that if we went to an episode-based system then I would have no copayments.

DR. WILENSKY: I don't know whether people -- I may have started this idea at this end. Let me go and have people at -- Hugh?

DR. LONG: I would favor the concept conditional on the safety net at the bottom end and a cap that would segue into our previous recommendation. And given the social safety net notion, I think that would address Alice's concern that you could then have it high enough that it would in fact cover the administrative costs.

DR. ROWE: I would agree. I would think that if you weren't -- we talked about 60 visits, and at $5 a visit, you're at your cap.

DR. WILENSKY: That's $300.

DR. ROWE: Then you're --

DR. NEWHOUSE: You're at case management.

DR. WILENSKY: Right.

DR. ROWE: And then you have your case management. So I think these ideas tie together nicely. I would agree with protecting those individuals who are already paying a very large portion of their income for out-of-pocket expenses for health care, and we've identified those populations.

The only thing I would disagree with what's been said is I disagree with Alice's formula. I don't think it's just what it costs to send out the bills minus what you collect, because the other piece in the equation is the amount of money you save by getting rid of some of the fraud. I think you have to add that in. If you did that, it may in fact be worthwhile.

DR. CURRERI: I'm reminded of when we set up an HMO in Mobile about 15 years ago and we were trying to decide what kind of copay -- we were going to cover all drugs, but we wanted a small copay. And it was interesting

to me that when we set the copay at $2 -- now this is 15 years ago -- the amount of drugs that were purchased were enormous. And when we raised it to $3 they dropped in half. And when we raised it to $4, it didn't change. So the difference between $2 and $3 made an enormous difference in the patients utilization of purchase of drugs.

So for that reason and that reason alone, I think that what somebody said over there, that you bring the patient into the financial obligation is probably the most important thing.

I'm also in favor of providing the appropriate safety nets for the poor, and I think you might even consider some appropriate safety net for those that have extraordinary expenditures because they can't afford Medigap -- for other kinds of therapy because they can't afford Medigap -- than paying a 20 percent copayment.

DR. WILENSKY: I think we started with Anne, but if you'd like another comment, you're welcome.

MS. JACKSON: No.

DR. WILENSKY: Let me phrase the recommendation that I heard, which is not uniform but it is a strong

consensus this year, seems to me to support a modest copayment, about $5, subject to a limit that is about $300 if we tie it into our case management, or whatever, a case review recommendation of 60 visits. That we exempt individuals who qualify for low income support programs associated Medicare. That is Medicaid, QMB, and SLIMB. And that this be -- unless a per-case or a per-discharge PPS payment were adopted, in which case some other type of financial mechanism would either be appropriate or whatever.

So I think it would be to cover it through either the present case, or if it turns out that we have a PPS, per diem. And I do not have any insight into where HCFA is going on this. I just think that we need to understand that they could fulfill the PPS requirement and stay at a per diem. So I think something that covered those aspects is consistent with the vast majority of opinion, understanding that the two who are not here had previously opposed the idea. But I think we have a much stronger consensus this year.

DR. KEMPER: It's clear that the low income exemption, or however to say that, that will be part of the

recommendation itself?

DR. WILENSKY: Yes.

MS. BUATTI: One last recommendation. This relates to the recommendation presented by Stephanie concerning a collection of common data element across post-acute settings. Patient characteristic information would help to identify the nature and overlap of post-acute services across different settings, and facilitate quality monitoring, and utilization review.

DR. CURRERI: So moved.

DR. NEWHOUSE: Done.

DR. KEMPER: As we have in the rehab and the SNF, can we add a recommendation on the quality monitoring with implementation of prospective payment?

DR. LAVE: I have another observation on --

DR. NEWHOUSE: Wait, let's deal with the quality monitoring. I guess the issue is, do we have enough quality standards to know quality when we see it?

DR. LAVE: Be developed.

DR. NEWHOUSE: If we're into monitoring, we ought to know what it is we're monitoring.

MS. NEWPORT: Does this fall into, we have to start somewhere?

DR. KEMPER: Janet's comment is you have to start somewhere.

DR. NEWHOUSE: You start with developing quality standards then. I mean, I don't know. This is an open issue. But it's not like we're doing a kind of cardiac procedure and we have indications and they're there or they're not there.

DR. MYERS: Could that be part of the recommendation? To develop and then monitor?

DR. NEWHOUSE: It could be that somebody who knows more than I do could say they're developed.

DR. MYERS: Continue to develop and monitor.

[Laughter.]

MS. BUATTI: HCFA will soon implement the OASIS for quality monitoring purposes.

DR. NEWHOUSE: But I thought the OASIS was going to describe and classify the patients.

MS. BUATTI: Perhaps I didn't explain it clearly enough in the paper. The patient classification system

that's being developed for the prospective payment system is based largely off of the OASIS data set, which was originally designed to measure outcomes in home health. It's not clear at this time how closely the patient classification system will resemble the original OASIS.

DR. NEWHOUSE: It's not clear that the outcomes have much link to home health necessarily. Are we just thinking this monitoring system is an outcomes measure or a process measure, or both?

MS. BUATTI: I think it's both. I'm not all that familiar with the mechanics of the OASIS. I know that HCFA had spent quite a few years examining this.

DR. NEWHOUSE: I'm comfortable with Woody's language, but I'm not comfortable that we really understand -- I, at least, really understand what's going on here. Woody's language seems to allow for --

DR. KEMPER: And it's being developed. OASIS is there but it's --

MS. BUATTI: Has not been implemented yet.

DR. KEMPER: -- not yet implemented.

DR. LAVE: I have a question about these

comparable data elements and for the whole issue of the MDS-PAC. We may want to say that there be a common set of elements rather, because the common data elements implies that we may want to do the full instrument, and there may be a subset of the instrument variables that make more sense.

DR. KEMPER: In different sets.

DR. LAVE: In different settings. So that we want a common set, but not necessarily the full set.

MS. BUATTI: Right.

DR. LAVE: I don't know, but I think we want to --

MS. BUATTI: Okay, I'll try to make that clearer.

DR. WILENSKY: Any further comments?

Let me share with you how I think we should use the rest of our time at our disposal. Before we stop for lunch I would like to revisit the PPS capital issue that we had left open because of some --

I'll do public comment on home health first. But before we break for lunch, take up the interest payment so that we can finalize our capital PPS recommendation. We are going to break for lunch. We will do the dialysis discussion after lunch. We have to revisit the

recommendations for Medicare+Choice, which I think will not be a long discussion, but it will be whatever it takes.

We may have a discussion of the first GME, medical schools and service-related income presentation. I don't think we will get to the second. If we can get to the first, we will do so. But because it is not part of our March 1st report, we will make sure that we get those items covered first. We will not break later than the time that we have indicated, because I know a number of you have planes and I don't want to disrupt your plans.

DR. CURRERI: We also need to revisit physician payment for the new recommendations that were worked out on PLI.

DR. WILENSKY: Yes, I think that is also a short discussion. We will do that at the beginning.

Let me first call for public comment on home health, and then the capital PPS.

MS. SULLIVAN: Hi, I'm Kathy Sullivan with National Association for Home Care. I'd like to thank the Commission for taking into consideration some of the recent changes in the home health payment system. But again, I'd

urge you to be clear in the March report and in your recommendations that we are dealing with a much more limited system and that access has -- the Commission has approved an access study separately from the recommendations. We would encourage that there may be some discussion of that as well.

On the copay issue, we are discouraged to see the Commission continuing on that and would like to at least offer the possibility that maybe it be implemented or there be some sort of a demonstration before it is fully implemented, since there are a number of issues raised by the commissioners that are unclear: how the exemptions would work, whether they would work. I guess those are my two main comments.

DR. WILENSKY: Thank you. Are there any other comments?

MS. BENNER: Hi, I'm Maura Benner. I'm with the Home Health Services and Staffing Association. I basically agree with a lot of the comments that were just made.

I guess I'd like to reiterate that right now we're under the interim payment system. We are not quite sure exactly what is going on, but we do know that the incentives

under the system have drastically changed from the previous system, and we feel that's very critical and important to understand at this point.

The second thing is that our association feels that it's extremely important for this industry to move towards a prospective payment system as quickly as possible. In that context, we would really appreciate if we could consider both coverage and reimbursement under that new system. So we'd be willing to work with the commissioners to move as quickly as possible to that system.

Thanks.

DR. WILENSKY: Thank you. Any additional comments?

Let's move back to the PPS capital update recommendation.

MR. GREENE: We're making copies at this time of some material we prepared in response to our discussion yesterday.

DR. WILENSKY: Joe, do you want to reiterate at least the issue while we're waiting for -- we've had some discussion of this while we're waiting for the material

before we have the presentation.

DR. NEWHOUSE: So let me see if I can give some explanation of where we are. The issue is how hospitals should be reimbursed for the financing component of their capital investment. When they make a capital investment, they tie up a certain amount of capital that could earn an interest rate, or they borrow money and pay and interest rate. And the issue is what interest rate to use in our recommendation.

Usually interest rates get grouped by whether they're nominal, which is the interest rates that most of us are used to, or real, meaning after inflation. And there actually is an observable market interest rate now that's real in inflation index bonds.

My view, after thinking about it some, and I think people think the Commission generally has a consensus now, is that for the update purposes it should be changes in the real rate of interest that affect the update. That changes in the nominal interest rate that are over and above the changes in the real rate reflect the market's expectations about inflation, which if they're correct will feed into the

market baskets downstream on both the operating and the capital side.

So that to give the hospital payment for the inflation part of the nominal rate would be to double pay. Therefore, we would use the changes in the real interest rate to talk about changes in the update.

In other words, if the real rate never changed, that would be in the base and we would just go along forever. Inflation over and above that would come in through the market basket updates.

DR. ROWE: Which interest rate would you use? In today's New York Times, the Treasury inflation bond rates are offered for a number of different durations or terms.

DR. NEWHOUSE: Right.

DR. ROWE: What would be the appropriate bond term?

DR. NEWHOUSE: We shouldn't work that out here. I would tell you what I would propose as a first go-around, which I would try to match the maturity for the average duration that hospitals were borrowing and use that maturity, or some weighted average over the distribution of

maturities that hospitals were borrowing at.

DR. ROWE: And what period of time would you use for the window during which the change occurred? Would it be an annual?

DR. NEWHOUSE: Yes, because it's an annual update.

DR. ROWE: Right, but this is the first time we're doing it.

DR. NEWHOUSE: Yes, so I would use an annual change in the real rate.

DR. ROWE: So then this would be the financing policy adjustment?

DR. NEWHOUSE: Yes, although what I'm proposing is very different than what went before.

DR. ROWE: Right. But that's the category.

DR. NEWHOUSE: I mean, usually I would expect the changes in real rates would be pretty low, so this is not -- basically this is kind of like close to dropping out that row most of the time.

DR. ROWE: If you look at what we have offered here now, it looks like it would be from 2.9 to 2.3, 2.4, about half a point?

DR. NEWHOUSE: The financing policy adjustment --

DR. CURRERI: No, you're looking at -- this is for change from year to year.

DR. ROWE: Yes, that's what he's talking about. I'm looking at the change in the real interest rate.

MR. GREENE: You can't tell that, tell the adjustment from the handout --

DR. CURRERI: The change from year to year would be negative between '98 and '99.

DR. NEWHOUSE: This is also different than I would calculate it, because this is calculated using the nominal interest rate minus the CPI change, which is another way to do it.

DR. ROWE: But we can look it up in the paper.

DR. NEWHOUSE: You can look it up in the paper. There's different ways to do this and they're going to mostly give you the same answer. They won't always give you exactly the same answer. We shouldn't, I think, try to -- that's enough of a detail that we shouldn't try to work that out here, exactly how we get to a real rate.

DR. ROWE: So what we want is a recommendation on

the method?

DR. NEWHOUSE: Yes. And then we actually have to plug a number in for this year.

DR. WILENSKY: Now it turns out that if we want to go to -- do you have this in an overhead?

MR. GREENE: No.

DR. LONG: We also have a question, do we not, that since we haven't done this in prior years, whether this time we're just doing a one-year adjustment or whether we want a lookback for a longer period of time.

DR. ROWE: To re-base it.

DR. NEWHOUSE: Yes. I mean, in principle that issue arises. I would not want to take that on today. If we were to do that, then we ought to debate that over a longer period of time and do it next year.

DR. LONG: Because that's what the original slide did was looked at it, change from a 15-year average or something.

DR. LAVE: Right. But remember, that was the first time we saw that slide. So that was the first time we tried to do it, which is what caused us to think about it.

DR. NEWHOUSE: No, we always had -- there was always a floating around in, have long term nominal interest rates changed? Even when I came onto ProPAC I remember seeing this --

DR. LAVE: Right, but it wasn't on the slide.

MR. GREENE: We presented it last year.

DR. NEWHOUSE: But we always said, it hadn't, so it was zero. My inbox said in, out, and too hard. This was too hard, so I didn't think about it. And we weren't going to do anything.

[Laughter.]

MR. MacBAIN: We're dealing here with an update factor that's a mix of change in dollar cost and change in rates, and I always get confused with that. So Joe, can you help me? Give an example.

If I'm thinking about purchasing equipment and let's say that inflation drives the cost of that equipment up 5 percent. That then increases the amount of the principal that I'm financing, which in turn, at a fixed interest rate, will also increase my interest expense.

Now if at the same time inflation also is

increasing the nominal interest rate, then that means that a higher rate is being applied to that higher principal. So I'm paying even more because the interest rate has changed. So in effect, I am experiencing the effect of inflation twice. First of all as an increase in the principal that I'm financing, and then secondly, in the rate applied to that principal.

If my reasoning is right, then we ought to be double counting it because people are actually paying the interest, are paying twice. They're paying interest on a higher principal, plus they're then paying a higher rate that also reflects that.

DR. WILENSKY: But you're not paying a higher real rate.

MR. MacBAIN: But they don't pay the real rate. They pay the nominal rate.

MR. GREENE: The methodology I was presenting yesterday, the results from yesterday, take account of that by comparing year to year values and total acquisition cost: interest, interest expense plus acquisition price in year two versus year one. And after looking at that, making that

comparison and working through the math, as they used to tell me in my graduate math classes, it can be shown that, and after the appropriate adjustments --

DR. NEWHOUSE: I think the answer, Bill -- go ahead. I'm sorry.

MR. GREENE: The adjustment from that comparison is rate of change in price plus rate of change in interest rate weighted by the financing share of financing and total cost, plus a second order interaction term which involves both, which is also going to be very small. So it was the first two, the rate of change in price versus this weighted interest rate change that in fact does take account of the price and interest component. You really get lost in the interaction term.

MR. MacBAIN: Again, are you talking nominal interest rate?

MR. GREENE: Nominal rates, yes.

MR. MacBAIN: So if you shift to a real interest rate, aren't we missing part of that impact that hospitals really pay out in real dollars?

MR. GREENE: They pay out --

MR. MacBAIN: I mean, they're living in the nominal world.

MR. GREENE: Yes, you miss -- in a sense that now you're talking the real world, you're not talking in terms of nominal dollars actually spent.

MR. MacBAIN: The real world is where we don't use real interest rates.

DR. CURRERI: Or real money either.

[Laughter.]

DR. LONG: Let me try it this way, Bill. Not that this is the real world.

But supposing that you were buying a capital asset that you were financing 100 percent, and that your loan contract indexed the principal to expected inflation so that the interest rate was a real rate. If the markets were efficient and expectations were realized, the rate of increase in the market value of your asset and the rate of increase in the amount of principal you owed would be equal and offsetting.

So your collateral would exactly offset your principal amount and what you would actually be paying net

would be the real interest rate.

The same thing happens if you load the inflation factor into the interest rate rather than into the amount you owe. So it's not really a double-count.

DR. ROWE: But doesn't that confuse the P&L with the balance sheet? I mean, the asset may be worth more, but the P&L --

DR. LONG: Well, it's a net worth. Think about net worth. You've got a liability, you've got an asset. They're offsetting. On the balance sheet there's no effect.

DR. ROWE: If we look at this, where did we get the minus 1.4?

DR. WILENSKY: It looks like it's zero. If you eyeball it, it looks like at least the real rate is zero. Not the nominal. The nominal has declined.

DR. ROWE: Yes, but comparing the last two points on the graph for nominal.

MR. GREENE: 1.4 percent yesterday was calculated as the rate of change in the interest rate, which is 1.2 percent decline on about a 6 percent rate. So it's about a one-fifth decline in the rate, and a financing share of

about 7 percent, which is interest expense over --

DR. ROWE: So it's not that the interest rate went down 1.4 percent, but it's 1.4 percent of 6 percent?

MR. GREENE: Yes, 1.2 of 6 percent weighted by a financing share, which works about to about 1.4 percent.

DR. ROWE: I understand.

MR. GREENE: Now following the same methodology with regard to real interest rates, the numbers you have there I get, instead of minus 1.4 percent, a minus .3 to .6 percent, depending on exactly how you do the calculations. I think the .3 is probably more reasonable.

DR. WILENSKY: So it's pretty close to zero.

MR. GREENE: Yes. And as you can see, for example, a real interest rate is about 3 percent, the average real interest rate both in 15-year --

DR. ROWE: So is that the number that you propose we plug into this for this year?

MR. GREENE: The same methodology would get a minus .3 percent, because there's much, much less variation. Instead of rates going down 1.2 percent here, they go down .4 percent in making this comparison.

DR. WILENSKY: Right.

DR. ROWE: And that really shrinks the range, because we don't have a range --

MR. GREENE: Yes. Again, you could have a zero, whatever, zero to minus .3, but the effect is much less.

DR. WILENSKY: Yes, it shrinks the range.

MR. GUTERMAN: With that range, with a zero to minus .3 you get a range, bottom line, of from minus 1.1 percent to plus 1.8 percent on the update for capital.

DR. WILENSKY: Is there a recommendation that's part of -- was there a BBA or was there not for capital, or are we just in the phase-in?

MR. GUTERMAN: No, there's a recommendation.

DR. WILENSKY: What is the recommendation? Ours would be somewhere between minus 1.1 and 1.8, to plus 1.8.

DR. ROWE: Now HCFA is going to -- picks the number.

MR. GUTERMAN: The Secretary. This number is not set in law.

DR. ROWE: I understand that, and this is our recommendation. Does HCFA staff have a recommendation?

MR. GREENE: Not at this point.

MR. GUTERMAN: They will on March 1st.

MR. GREENE: We know that their market basket number is very close to what we get from combining our finance adjustment.

DR. ROWE: So we're going to have to have a narrative, have a fair amount about the Newhouse approach to the interest rate.

MR. GREENE: So the combined interest adjustment and market basket does come out to be significantly more than the HCFA market basket.

MR. GUTERMAN: The discussion of the Commission's recommendation on the capital update generally emphasizes the fact that when the transition on capital payment is finished that there really should be done prospective payment rate for hospital inpatient services anyway.

DR. WILENSKY: Right.

MR. GUTERMAN: So since this range encompasses the update on the operating side that the Commission decided on yesterday, it's consistent with that.

DR. WILENSKY: I think, unless there is further

discussion, we have consensus on the update recommendation. We will break until 1:30. We'll reconvene in public session at 1:30.

[Whereupon, at 12:33 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:54 p.m.]

DR. WILENSKY: We are going to try to finalize recommendations in two areas before we turn to the section on renal dialysis which we did not get to at the end of the morning session. The first is to finalize recommendations regarding physician liability. We went through most of the physician recommendations at the end of yesterday's session. We had asked for some additional suggestions and we're going to cover those first.

Kevin?

MR. HAYES: I met this morning with Joe and Ted, and a new recommendation was drafted and that was handed out to you. You can see on the first page of this handout that the next text is identified with italics. You can see that a phrase was added to the first sentence of the recommendation about -- we removed the mention of the risk of service method and substituted frequency of closed malpractice claims with payment by service as a basis for PLI expense RVUs.

Then there's some supporting text which explains what the Commission's position might be with respect to use of those closed malpractice claims. You can take a second to look over that.

DR. ROWE: So moved.

DR. LONG: Second.

DR. NEWHOUSE: Any opposition?

Done.

DR. LEWERS: No opposition. I was distracted, but no opposition.

MR. HAYES: Then you also asked at the end of the

day for a new recommendation having to do with HCFA publishing an estimate of conversion factor updates prior to publication of the final conversion factor update for a year. So we have a recommendation to that effect on the second page of the handout and some supporting text.

DR. ROWE: So moved.

MR. HAYES: We picked the date of March 31st here to try and make it compatible with the Commission's schedule. You would have a meeting in April, and so it would be possible, with timely publication of this information by HCFA for the Commission to consider it at an April meeting.

DR. WILENSKY: Any question or comment on this? All in agreement?

Okay. Thank you very much, Kevin.

At this point we want to return to the Medicare+Choice recommendations that we reviewed yesterday. There was some specific concern about whether or not we should include a time for the phase-in and whether to go with the blend, and realized that by picking up a certain time that we might resolve any concerns we had about the

lack of a corridor. So I don't know whether you wish to have us go through each of them or only focus on some of them.

MS. THOMAS: In addition, you added the one on the ACR submission date yesterday, and I've come up with draft recommendation language here. It's fairly unspecific.

Beth Docteur did meet with people at HCFA yesterday and had a discussion about their timeframes on the information dissemination aspect of things and they seem to be quite tight. And they have a feeling that they've got a lot of congressionally-mandated deadlines and if you move one you might also give consideration to moving others as well.

But as drafted, this is a very vague -- I mean, there's no specific date here, so it just alerts the Congress and HCFA to the need to consider.

DR. WILENSKY: I don't know if they had a specific request. What we were proposing was a shift in two months as opposed to effective postponement or delay in terms of reports.

MS. THOMAS: I'm sorry to be confusing. I meant a

shift in the deadline. But as drafted, this sort of avoids the need to specify the date.

DR. WILENSKY: Let me focus specifically on the recommendation with regard to the risk adjustment should be phased in and using a blend approach.

MS. ROSENBLATT: I would just recommend, given what we just heard, that we change it to be something like, we support HCFA's plan to phase in the new risk adjustment system, and keep it simple like that and leave everything else out.

DR. WILENSKY: We may just want to put in, a five-year phase-in system.

DR. ROWE: That was very helpful of them to come. Thank them for us. I'm sure you have.

DR. WILENSKY: That uses a weighted blend. So I think that we can use that. But just specify that we support the proposal that HCFA has made for a five-year phase-in.

MS. THOMAS: Okay.

MS. NEWPORT: There was an earlier suggestion that maybe we combine the language into one overall

recommendation.

DR. ROWE: I talked with Jennifer about that. There's a process whereby she's organizing all the recommendations.

DR. WILENSKY: That will be something that we will make sure is distributed to commissioners before it is finalized to make sure that in redrafting or stylistic purposes that we don't feel that we have changed the sense of the recommendations.

MS. NEWPORT: Thank you.

DR. WILENSKY: Were we not under quite so much time pressure, we would review with you where HCFA is with regard to their risk adjustment. But because we are under a lot of time constraints, either check on some of the news reports or a couple of articles in which it's summarized or it's on their web page, and you can pull it up. Normally, we would be more accommodating, but we have an enormous amount yet to try to get through today.

MS. THOMAS: So just to clarify, do you want to leave the language here and also add that we support HCFA's position, or change it just to a vote of support for HCFA's

position, for HCFA's plan?

DR. WILENSKY: I think we ought to begin the statement that we support HCFA's position for a five-year phase-in, and that we then include our language that -- or that includes the blend approach. So that we're on record of both that we're supporting HCFA and that we are, by extension, also specifically supporting the use of a five-year phase-in and a blend.

MS. ROSENBLATT: And maybe even a back-end loaded --

DR. WILENSKY: Back-end loaded. I think that was part of our earlier discussion because of the concerns about withdrawals and data difficulties, a back-end loading is appropriate, as suggested by the rule or as is included in the rule.

MR. SHEA: We're not making a recommendation in regard to the county risk factor, are we?

DR. NEWHOUSE: We agree with the HCFA position. At least some of us do.

DR. WILENSKY: We had not intended to make a specific recommendation. By implication, we are supporting

what HCFA is doing.

MR. SHEA: Right. I'm not suggesting we should. I just wanted to --

DR. NEWHOUSE: Or did you mean to re-scale the old factor -- the question Alice asked yesterday? Because the new factor is just sort of a technical thing to keep it neutral.

MS. ROSENBLATT: Which I asked again.

DR. NEWHOUSE: You asked it and they said, no, they're not re-scaling.

MS. ROSENBLATT: His answer was that they were doing it the way I thought we all thought they were doing it.

DR. NEWHOUSE: Yes.

DR. LONG: Right. They'll continue the old rate book.

DR. NEWHOUSE: Yes.

MR. SHEA: But apply this factor.

DR. LAVE: To the new stuff.

DR. NEWHOUSE: Just to the new component.

MR. MacBAIN: You don't need to do it until you do

the per-beneficiary risk adjustment.

MR. SHEA: I just asked Bob this question at the end and I thought he said, no, it does get applied.

DR. LAVE: To the risk adjustment factors.

MR. SHEA: No, I thought he told me it would apply to all.

DR. NEWHOUSE: Maybe we need to clarify that.

DR. LAVE: I thought we asked it and he said --

DR. NEWHOUSE: Alice certainly asked it.

MS. ROSENBLATT: And the answer he gave me made it sound like there's an old rate book and a new rate book and that's what you blend in.

DR. LEWERS: That's right. And the old rate is going to continue --

DR. NEWHOUSE: And I went through the rule and that's what it looked like to me, too.

MS. NEWPORT: That's how that blend has to --

DR. WILENSKY: I think at this point we will try to clarify. Technically, at this point it appears that it is consistent with what we had described.

DR. NEWHOUSE: Did you have a concern, Gerry, one

way or the other?

MR. SHEA: No, I was just trying to understand it.

DR. WILENSKY: Are there any further issues that people wish to raise with regard to the recommendations, the substance of the recommendation?

Okay, thank you.

Dana, renal dialysis?

MS. KELLEY: As you know, MedPAC is required to recommend an annual update to the composite payment rate for the facility component of outpatient dialysis services. Today I'm going to review Medicare's payment for these services, discuss the update framework, and then ask you to determine your update recommendation.

Since 1983, dialysis facilities have been paid a prospective rate for each dialysis treatment they provide. This rate, called the composite rate, covers the bundle of services, tests, drugs, and supplies routinely required for dialysis treatment, regardless of the type of dialysis used.

The composite rate represents the national median cost per treatment weighted by the percentage of patients dialyzing in each site. The rates were calculated in 1983

based on a sample of cost reports from 1977 through 1979. The rates therefore reflect the mix and cost of inputs, and the proportion of patients dialyzing in different sites at that time.

Unlike Medicare payments to other providers, the composite rates have not been updated annually. The rate for hospital-based providers is $126 per treatment, and for independent facilities is $122 per treatment.

To help you decide if an update to the composite rate is necessary for fiscal year 2000 staff has analyzed how dialysis costs might change between 1999 and 2000. To do this we use a framework similar to that used in the update recommendation for PPS hospitals. You might also want to make a discretionary adjustment based on evidence regarding facilities financial performances and the quality of services they provide.

In preparing the information to support your update recommendation, we analyzed data from unaudited cost reports for 1992 through 1996. We had hoped to have data from 1997 to present to you today. Unfortunately, we've experienced some delays in getting that data, but we hope it

will be available for publication in the March report. We have every reason to believe the trends that we've seen over the last few years will continue in 1997.

I'm presenting only our analysis of data submitted by independent dialysis facilities since we've encountered so many problems with the data submitted by hospital-based providers. Keep in mind that more than three-quarters of dialysis providers are independent facilities, and almost 70 percent of dialysis patients are treated by independent providers.

The update framework includes a market basket index to reflect input price changes. Analysis of the market basket for dialysis services indicates that prices for dialysis facilities will rise an estimated 2.2 percent between fiscal year 1999 and 2000.

We also consider the scientific and technological advances and productivity improvements. Whereas the market basket measures the change in input prices, the productivity improvement and S&TA adjustments measure changes in the use of inputs. These adjustments reflect your judgment of how much the cost per dialysis treatment can be expected to

change as a result of gains in productivity and of scientific innovations.

We estimate that facility costs will rise between .2 and .7 percent due to S&TA. At the same time, we do not believe providers will be able to offset these increased costs through gains in productivity.

DR. ROWE: Is there anything, Dana, about -- every time we get to S&TA we talk about Y2K. Is there anything about dialysis in particular that makes them any more or less susceptible to Y2K issues?

MS. KELLEY: Our assessment was that they would face basically the same issues that hospitals do. The dialysis machines obviously will need to be Y2K compliant. They'll also have other administrative, computer issues that will need to be taken care of. And that's where the .2 percent came from.

DR. LAVE: Can I ask a productivity question? Now with all the physicians here I'm going to get the language all wrong. But my understanding is that, having read your material, that the number of dialysis sessions per unit has decreased a little bit, probably because the length of time

for dialysis has increased in order to KT over V, or KV over T, or something like that. So if in fact one were to do more -- and I think that the recommendations of nephrologists is that this KT over V ought to be better than it is.

So if in fact the facilities were to conduct more things according to the appropriate K2 over V, wouldn't that imply a productivity decrease?

DR. ROWE: You're evolving KV over T into Y2K.

[Laughter.]

DR. LAVE: Anyway, if in fact they increased the -- wouldn't we expect to see productivity to decrease rather than increase as measured, if in fact --

DR. NEWHOUSE: That's how you measure productivity.

DR. LAVE: That is true. But if I take the number of staff time needed to dialyze, if that's slightly to increase --

DR. NEWHOUSE: Through-put, you mean.

DR. LAVE: -- because of the pressure to increase the dialysis length. I don't know how to --

MS. KELLEY: Yes, our expectations are that there are no cost savings to be gained by providers increasing their productivity.

DR. LAVE: I'm asking whether or not we might expect it to be worse because of this factor.

MS. KELLEY: Absolutely, yes.

DR. ROWE: Why did you change from what you had in your chapter to what you have on the slide?

MS. KELLEY: For S&TA? An assessment was made that, or a decision was made that it should be similar to the increase that was decided upon for hospitals, because there was no indication that it should be greater. In fact, the scientific and technological advances in dialysis are rather small. We're not expecting any big technologies to come along.

DR. ROWE: So this is the number that we agreed on yesterday for this item.

MS. KELLEY: This was the number that was the baseline that you considered yesterday, and I understand you changed it because of concerns about Y2K.

DR. ROWE: Right.

MS. KELLEY: This is the same base you started with yesterday.

DR. ROWE: So your rationale would be that whatever this item was yesterday is what it should be for dialysis. That it should be the same as for hospitals. You didn't think it should be different.

MS. KELLEY: Whatever your determination about Y2K, I think would be appropriate for dialysis facilities as well, yes.

DR. CURRERI: There's something that troubles me about this chapter, so you're going to have to help me out. As I understand it, independent dialysis centers are getting paid for what their costs were between 1977 and '79 and there's been no increase; is that correct?

MS. KELLEY: That is correct.

DR. ROWE: We increased it last year.

DR. CURRERI: No, we didn't. We recommended it.

DR. LEWERS: We recommended it. It was not approved. It's been recommended several times.

DR. CURRERI: But now what I don't understand -- that means several things to me. Either they were way

overpaid back in 1983 --

MS. KELLEY: I think that is true.

DR. CURRERI: Or they really improved their productivity over the years.

MS. KELLEY: Also true.

DR. CURRERI: But at the same time, that's hard to believe because there have been some big time items like erythropoietin that came in here --

DR. NEWHOUSE: That's paid separate.

MS. KELLEY: Erythropoietin is paid separate.

DR. CURRERI: So is it a combination of both of those things?

MS. KELLEY: It's both those things. I think it's generally recognized that facilities were greatly overpaid at the beginning of this. In addition to that, throughout the 1980s there were large productivity gains made. The time of dialysis decreased quite a bit. There was an upswing in the use or the reuse of dialyzers. So that instead of having a new dialyzer each time a patient was dialyzed, the dialyzers are now reused quite a bit. There was a decrease in the skill mix of the staff in dialysis

facilities.

So I think it was a combination of both those things, yes.

DR. LEWERS: And monitoring issues improved, so your productivity for staff --

DR. CURRERI: I just wonder if somewhere in the chapter you might just say what you just said.

MS. KELLEY: Okay.

DR. CURRERI: Because it wasn't clear to me what were the factors that allows them to still have a payment to cost ratio of over one and not have had an increase in 22 years.

DR. NEWHOUSE: The cost has to be kind of in quotes, too.

DR. LEWERS: Right.

DR. NEWHOUSE: Because of the auditing problem.

MS. KELLEY: Yes.

MR. GUTERMAN: There's another issue too, and that's the dominance of Medicare in that market, means that the cost that they may experience at any given time are, shall we say, flexible. So they can respond and will

respond to the level of payment in terms of determining their cost. So in a market where Medicare was a small part of the market, then you can envision some kind of cost structure along which facilities move. But with Medicare so dominant in the dialysis market, facilities can adjust their costs.

The question then is what that does to quality.

DR. MYERS: Do you have a number for dominant? I mean, what percentage of that dialysis is Medicare dialysis?

MS. KELLEY: About 90 percent.

DR. LEWERS: 90-plus percent.

DR. MYERS: Is that pretty even across all of these hospital and --

DR. LEWERS: I think so.

MS. KELLEY: I think it probably is, although I don't have numbers on that for sure.

DR. LAVE: I have another question. Again, we struggle with this all the time because of the positive profits and the quality implications of containing costs. Some time ago there was fairly good evidence that the mortality rates, as far as one could look at them for

American patients with ESRD, were higher than those in fact observed elsewhere. I was wondering whether or not in fact that relationship has stayed about the same, whether or not it's gotten better, or whether or not it's gotten worse.

MS. KELLEY: I haven't seen any evidence that would lead me to believe any of those things.

DR. LAVE: Does the USRDS publish that data every year? Have you looked at their latest report?

MS. KELLEY: The USRDS does publish data on the U.S.

DR. LAVE: But not the comparative studies?

MS. KELLEY: But not comparative information. They do, for lack of a better word, a literature review talking about international comparisons. But as you know, the international comparisons are really plagued by lack of a good case mix adjuster.

DR. LEWERS: We've had that discussion before and I think that it's important to note that it's our June report that's going to have more of an issue on quality, and I think that that debate needs to wait till that time. There are reasons for that. I don't think it has to do with

this, with our time constraint. We can get into it if you want to, but at this point I think that's something we ought to debate at a later time when we have more time. And it is the quality issue that's related. There are good reasons that can be quoted as to the change in data and all on this.

DR. LAVE: I agree with you, I don't want to push that here. But we always have this -- the problem that one has in this area is the one of trying to make arguments to justify a rate increase, if we feel strongly. As Stuart has pointed out, if you fix a rate and people are trying to stay in business, they will reduce their costs to come under that rate. The question is, do the costs get reduced significantly so that it impedes quality, in which case we may want to say more. It had to do with an update --

DR. LEWERS: The IOM study of several years ago suggested that we were at that point.

MS. KELLEY: Right.

DR. LEWERS: I think there are a lot of reasons why you can change costs, and I think that the industry is changing. It's much like the managed care industry. We're getting into a few large players who are playing, so they're

cutting costs because of basically their size. And you're taking a look at more and more facilities are being sold and ending up in very few conglomerates, if you want to call it that.

So I think that that does cut costs. So I think there are other factors that are part of that.

MS. KELLEY: Our analysis of the cost data has shown that there are significant economies of scale. There's also a lot of vertical integration in this industry.

DR. LEWERS: Yes.

DR. MYERS: I agree with the recommendation. Are there ways that we can word these this time so they get -- I mean, can we add, we really mean it this time? Are there ways for us to get attention to this such that we don't get the same result? If we keep doing the same thing and getting the same result, then that should tell you something.

DR. NEWHOUSE: I think it's futile.

DR. WILENSKY: I think that we certainly should continue making the recommendation that we think is appropriate. There has not in the past been a lot of

support for this, and if it didn't get into BBA '97, I don't know how much I hope I would have that we can expect a different outcome. But I definitely think we should make the recommendation, if we think it's appropriate, despite our past history of failure to get action.

But if anyone has any thoughts about how to try to be more convincing, or raise this more often. I think one of the things that may perhaps happen is that because it doesn't tend to be high on the agenda for very many groups, except for a very focused lobbying activity, it probably doesn't get as much attention as other areas. At least my observation has been it hasn't gotten as much attention.

And because there has seemed to be a lot of -- or continued entry in an area, that there doesn't seem to have been the sense that as long as you are having more groups want to come in and try to supply services, it doesn't suggest that there's an imminent problem.

There's been less concern about the mortality rate issue than I would have thought normally would be the case.

MS. KELLEY: To echo what you were just saying, Gail, as recently as 1996, the data indicate that the

industry is still growing at about 9 percent per year.

The mortality rates have been coming down. So even though we do have this comparison between the U.S. and Europe in particular, that that makes us a little concerned about, or more than a little concerned about quality, it is true that mortality rates are declining in this country, even as the age of --

DR. MYERS: Couldn't the growth be explained by new patients who prior to this time may have died of their diseases who now need dialysis?

MS. KELLEY: True, that is a possibility. But the age of dialysis patients is also increasing markedly. So half of dialysis patients are now over 65, which is pretty impressive.

DR. ROWE: The growth that's of concern is not the number of patients, but the number of companies and entities that wish to sponsor dialysis units. The idea being that if this was grossly underpaid and there were no profit, why would there be entry? That's the entry that --

DR. WILENSKY: Right. It's the flip side of the comment I made yesterday about the HMO plans. As an

economist, I look at exit and then have trouble reconciling with statements about all kinds of excess profits. On the other side, if you see entry, whatever our other estimates are, it doesn't suggest an absence of profits.

And with regard to the mortality rates, we do need to make some kind of adjustment in assessing mortality rates for the differential dialysis rate that we have in the United States, so that we are also dialyzing different kinds of patients than are being dialyzed elsewhere.

DR. LEWERS: We're dialyzing everybody.

DR. WILENSKY: Right. That is what I was trying to say, yes.

DR. ROWE: So do we have a number?

DR. WILENSKY: Yes.

MS. KELLEY: Now if we could skip down to S&TA for a moment, the adjustment that was made for PPS hospitals for the Y2K issue was an additional .3 percent; is that correct?

DR. CURRERI: It was .3 to .5.

MR. GUTERMAN: No, it was .5 to 1 was the final.

DR. MYERS: Should the Y2K be equal in both the hospital and the non-hospital?

MR. GUTERMAN: Do you think it should be the same?

DR. ROWE: I don't know. I asked Dana and she said she didn't --

MS. KELLEY: My expectation is that --

DR. WILENSKY: Wait a minute. The .5 to 1 was the whole S&TA.

MS. KELLEY: Right.

DR. WILENSKY: And the incremental change we made yesterday was .2?

MS. KELLEY: I thought it was .3.

MR. GUTERMAN: It was .3

MR. MacBAIN: In addition to --

DR. WILENSKY: Thank you. So it was .3.

MR. ASHBY: But wait a second. Let me just add one thing on that. We had already added in the .2 in the first place. So really we were adding .5 to the Y2K when all was said and done.

MR. GUTERMAN: Another way to put it is, your estimate of the S&TA factor for hospital inpatient was .5 to 1. And the question is, do you think that the effect on cost of dialysis facilities should be greater, less than, or

equal to that?

DR. WILENSKY: No. My sense would be less, although I would -- Ted, if you --

DR. LEWERS: You don't have the size of the facilities, et cetera?

DR. ROWE: I have no idea. I certainly don't think more.

MS. KELLEY: No.

MR. GUTERMAN: So is the .2 to .7 right, or do you want .3 to .8, or it doesn't really matter?

DR. WILENSKY: I think the .2 to .7 seems adequate to account for that, given what we have proposed for inpatient hospital.

MS. KELLEY: So that would mean we're considering an update between 2.4 and 2.9 percent.

DR. CURRERI: I just worry. Something just doesn't seem right to me. For a fee that has been absolutely level for 16 years, there's something wrong. I just wonder if there should be some sort of discretionary adjustment.

DR. NEWHOUSE: I think we have to do more work.

DR. WILENSKY: Yes.

MS. KELLEY: It's also true, Bill, that the facilities do get paid for many other services besides the dialysis services.

DR. CURRERI: Yes, I know.

DR. WILENSKY: I'm sympathetic, in principle, with the notion that a rate that has stayed constant for so long doesn't seem right.

DR. NEWHOUSE: But then there is this entrance.

DR. ROWE: Or it wasn't right before.

DR. WILENSKY: But I think that at this point all we can do is to say, we're concerned, or we have some questions about the constancy of the rate. We acknowledge that there has continued to be entrance into this area, and until we do further analysis to try to have a better understanding about the cost and quality issues, we're not in a position to make a recommendation other than the one by component which is what we're showing.

DR. CURRERI: Except that I think that if you take Judith's point, and I think it's reasonable, to think that productivity is going to go down, not up --

MR. GUTERMAN: But remember, that zero is really a net effect. I mean, there's this sort of general trend in productivity you expect from a set of facilities. So if you count that as a negative adjustment and then you count your reservations about wanting to push that too hard, on the other side that results in a net of zero. So that really is an offset of the normal increase in productivity you'd expect from any set of concerns.

DR. ROWE: It seems like if we're going to save any souls here it's going to be not so much on what the number is, but the language and the force with which we deliver the message.

DR. WILENSKY: Right.

DR. NEWHOUSE: Or I would have said, if we're save souls if it's going to be through our future analysis that will shed some more light on this than we've done today.

DR. WILENSKY: That also. But we will try to be as clear in our writing as we can that we think increases have to be made in this area. We think we've taken a very conservative approach in recommending the increase, and we need to do further analysis before we can make any other

statements.

DR. ROWE: So it's 2.4 to 2.9?

DR. WILENSKY: Right.

DR. LEWERS: And we were 2.7 last year?

MS. KELLEY: Yes.

DR. ROWE: And that didn't get done?

MS. KELLEY: No.

DR. WILENSKY: We're consistently ineffective.

DR. LAVE: And we had a rate of increase the year before that in ProPAC.

MS. KELLEY: Are you comfortable with the range?

DR. WILENSKY: Yes. Thank you very much, Dana.

We are going to do one session on graduate medical education before we conclude this afternoon. We're going to do the one that was scheduled for 1:30, graduate medical education with regard to issues regarding medical schools and service-related income. Deborah?

DR. LAVE: Gail, before we do that, do we want to talk about this letter about money to HCFA, because that would be a recommendation in the March report?

DR. WILENSKY: Okay. We've lost some people, but

let me raise the question and we can see whether we can answer this now or whether people need more time to look at it. Is there a sense among the commissioners who are here that they would like to have either the full version of the Health Affairs letter or a summarized version of the Health Affairs letter be a part of our recommendations?

MS. ROSENBLATT: Given that it was signed by you two and Leonard Schaeffer, I'd like to see it there, and I'd like the Commission to take a stand that we too, with our signatures, are in support of the statements made.

DR. ROWE: Given the time and given -- I mean, we could spend six weeks trying to wordsmith this into another thing, but why not just add, for what it's worth, our imprimatur to this?

DR. WILENSKY: Okay. I am very pleased to have the Commission add its weight and imprimatur to this.

DR. ROSS: Where would you like that added? As a separate feature in the introductory matters to --

DR. WILENSKY: I think actually, given that we are going to be making a series of recommendations, many of which affect the operations of HCFA, that it would be good

to come at the front.

DR. KEMPER: When you say up front, that means in the introductory chapter?

DR. WILENSKY: Right. I think before we go through all the other things we're about to lay on HCFA, it would be appropriate to have this message. Whether it's literally in the front chapter or as a separate piece we'll leave to our executive director.

Deborah?

MS. WALTER: The academic community contends that changes in the health care environment, including several recent changes to Medicare, are adversely affecting faculty practice plan revenues and are presenting serious challenges to medical schools' ability to focus on their core missions of education, research, and service delivery. It is asserted that the ability of medical schools to sustain the current level of clinical support for academic programs is in jeopardy.

In an effort to compete in an environment increasingly dominated by managed care, academic medical centers, or AMCs, are under increasing pressure to offer

clinical services at more competitive prices. This has made it difficult to maintain the flow of practice revenue. Other AMCs have responded by focusing on service delivery almost to the exclusion of their other missions of education and research.

Given this growing concern, MedPAC was specifically directed by Congress to address the dependence of medical schools on service-generated income as part of its study of graduate medical education. Today I'm going to address two primary issues which are outlined there.

The data presented will focus on '87-'88 data to the present, for several reasons. Much of the data we used in our analysis was obtained from the AAMC. Their annual financial data collection instrument, otherwise known as the LCME questionnaire, was significantly revised in '87-'88 to more fully capture and report sources of medical school income. This reporting change makes comparisons to prior years a little less relevant.

And for the first time in '87-'88, osteopathic medical schools also separated sort of broke down variables and reported them separately, variables that are of interest

to our analysis. So again, it makes it difficult to correctly identify historical trends prior to '87-'88.

In terms of the first question, how dependent are medical schools on service-generated income, I think the answer is, very. Service-generated income includes revenue from clinical earnings of faculty, more commonly referred to as the faculty practice plan revenue. Revenue from faculty practice plans is the primary source of service-generated income for medical schools.

Revenue from faculty practice plans are extremely important for several reasons. First, it is discretionary, or unrestricted funds that can be used for a variety of purposes. Examples include underwriting faculty recruitment efforts. It is also, and probably the most important, the main mechanism in compensating clinical faculty for time spent in non-patient care activities.

These revenues are also frequently used to cross-subsidize research. For example, faculty practice plan revenues are often used to provide seed money for faculty research projects, or to sustain established faculty between grants.

The growth in revenues from faculty practice plan revenues has been relatively stable over the last few years, as you can see in this graph, for both allopathic and osteopathic schools. But I think that the more important point here is that since '93-'94, allopathic faculty practice plan revenues account for over one-third of medical school revenue for allopathic medical schools. In contrast, this source represents a relatively small percentage for osteopathic medical schools.

To further illustrate my point I'm going to quickly show these next two slides to show how various revenue sources that are supporting allopathic and osteopathic medical schools in 1996-'97. In 1996-'97, faculty practice plan revenues comprised 34 percent of all revenue for allopathic schools. I think it's also important to note that clinical services provided to Medicare patients accounted for approximately 12 percent of the faculty practice plan revenues.

DR. NEWHOUSE: Can I ask you a question? If I understand this right, other grants are a subset of total grants, so we should probably drop out that other grants

bar.

MS. WALTER: No, I think they're separate. Total grants and contracts --

DR. ROWE: That's probably federal.

MS. WALTER: Yes.

DR. NEWHOUSE: But the dollar amount is the total. She means to distinguish, I think, federal and other.

MS. WALTER: You're correct. I'll make that --

Just by comparison, if we look at osteopathic schools, faculty practice plan revenues comprise only 17 percent, behind the state appropriations, and tuition, and fees.

DR. ROWE: Could you back to the sentence before Joe's question? Was it 12 percent of the dollars? It was 12 percent of what?

MS. WALTER: Medicare patients accounted for approximately 12 percent of faculty practice plan revenues in that 34 percent of faculty practice plan revenue.

DR. ROWE: So it's 12 percent of 34 percent?

MS. WALTER: Yes, correct.

DR. ROWE: So one-eighth of that number.

MS. WALTER: Right.

DR. ROWE: That's surprisingly low.

MS. WALTER: It is. That was the data that we got from the AAMC as far as I understood it.

DR. ROWE: It's not 12 percent. It's 12 percent of 34 percent? It's only 4 percent?

MS. WALTER: It's low, right. Of the 34 percent, 12 percent is Medicare.

DR. ROWE: Which is only 4 percent of the total medical school revenues according to that.

MS. WALTER: Right, according to the data as I understand it.

DR. NEWHOUSE: For example, if I take the Harvard Hospitals, which are unusual, the faculty practice plans may be over in the hospital, so the medical school doesn't count. So there may be some other anomalies like that.

MR. MacBAIN: On the osteopathic schools, my understanding is traditional for a large share of the faculty to be independent practitioners who are supporting themselves from their own practices. That's analogous to the practice plan revenue, but it wouldn't show up in the

statistics.

DR. ROWE: I'll give you an example. One faculty practice plan that I'm familiar with has revenues of about $160 million a year; 80 percent of those revenues come from hospitalization. Only 20 percent come from seeing patients in the offices that are on our campus. And most medical schools, or many medical schools, have full-time department, where everyone is a full-timer, Bill. And the ones in our place, which are not unusual, include cardiovascular surgery, vascular surgery, neurosurgery, anesthesia. These are full-time.

So one would think, therefore, that a disproportionate portion of those revenues would be Medicare, not disproportionately lower. That's why it just doesn't make sense.

DR. CURRERI: Unless they're not documenting what the residents do.

DR. ROWE: In which case they should go to jail forever.

[Laughter.]

DR. CURRERI: No. They don't charge, for that

reason.

DR. ROWE: But if somebody gets a heart operation, they get charged -- believe me. Regardless of who does it. So I think we should just check with the AAMC. They're smart guys and they know what --

MS. WALTER: I know that they're here and that was my understanding from the data that we provided on page 6. But I know that they're going to correct me if I'm wrong on that.

DR. ROWE: That's fine. Go ahead. I'm sorry, I don't mean to -- it's just we need to understand.

MR. MacBAIN: It seems like there's something missing.

DR. ROWE: If the argument is that the change in Medicare is having this dramatic effect on medical schools, what you're saying is it's only 4 percent of the revenues.

MS. WALTER: Yes, I'm saying -- as we go through this, I'm saying that it's not a big piece of the pie. And that's sort of the argument in my paper is that it's not.

DR. ROWE: Right, I saw that. But I didn't see the percentage --

MS. WALTER: On page 6 of the paper it breaks down the different payor types and maybe that will help in terms of putting it into a little bit of perspective. Now you see Medicaid is the 8 percent and stuff.

DR. ROWE: Right.

MS. WALTER: So that's the information as I understand it from the AAMC. But again, I know that they're here to correct me if I'm wrong.

DR. NEWHOUSE: What is other? Health plans?

MS. WALTER: I don't know. We've had some discussions with the AAMC. I'm thinking it's like, perhaps for consulting fees, and perhaps clinical expertise and so forth that they're charging -- it's a huge category. It's 40 percent, and I haven't been able to pin them down on exactly what that means. We just know it's something other than Medicare and Medicaid and all of these -- you know Blue Shield. But past that, I'm not real sure.

DR. CURRERI: It could be HMOs.

DR. NEWHOUSE: That's what I asked, is it health plans?

MS. WALTER: I've asked and we just haven't been

able to catch up to each other yet.

DR. CURRERI: It could be HMOs and CHAMPUS and --

DR. NEWHOUSE: Well, there's CHAMPUS and worker's comp.

DR. ROWE: For our purpose it's not Medicare, right?

MS. WALTER: Right. So for the draft I thought, we'll definitely -- I mean, because it's such a huge chunk, we're definitely following up on it. But we thought, for the purposes, we know it's not Medicare. So I thought for that purpose, that's all we care about right now.

So back to my pyramid of osteopathic schools. As I had indicated, it's 17 percent of all of their revenue. And faculty practice plan revenue is even less important for private osteopathic schools, which currently account for 68 percent of all of the schools. So given their limited dependence on service-generated income, I'm not going to look at them specifically here today or include them in our analysis.

There are a few problems in terms of trying to determine exactly how important or dependent medical schools

are on service-generated income. The flow of revenue doesn't always explicitly flow through the medical school, and the data sources available won't allow us to accurately disentangle how money flows between the medical schools and the hospitals. There are really three issues and they're really interrelated.

One of the issues has to do with these cross-subsidies. Even if research is sponsored by external sources such as NIH or private sponsors, the medical school is expected to contribute to the research activities conducted by their faculty.

So institutional cost-sharing on sponsored research is made possible by the availability of discretionary revenues, derived in large part from clinical services. This is important because the magnitude of institutional cost-sharing on sponsored research projects that is supported solely from faculty practice plans are believed to be significant, ranging anywhere from 10 to 25 percent.

Another problem we have in terms of disentangling how money is sort of flowing between hospitals and the

medical school is this off-the-books, on-the-books issue. Off-the-books revenue are revenues and expenses which benefit the medical school programs but are received or borne by entities other than the medical school. In '96-'97 medical schools reported over $5 billion of hospital revenue supporting medical school programs, but only 42 percent, which was about $2.2 billion, were recorded on-the-books revenue.

Examples of off-the-books revenue may include the paid salary of faculty or house staff, or grant and contract agreements between affiliated institutions and external agencies. Medical schools report these off-the-book revenues when they complete their financial statements to satisfy LCME accreditation requirements regarding their financial stability, but we have no way of knowing the details or tracking the specific items included on the off-the-book revenues.

And somewhat related is this lack of accurate cost accounting. Of course, it's the medical school that's the sponsoring institution of GME programs, but the hospital, not the school, is the direct recipient of payment from

Medicare and Medicaid for its share of GME under Part A. So in many cases, GME activities are supported by transferring hospital revenues to the medical schools solely because the residents' salary are paid through the school. So this is representing a pass-through as opposed to a subsidy that the hospital directly provides to the medical school.

A portion of these hospital revenues are also transferred to medical schools to pay for services by clinical faculty per contractual arrangements between the entities. So there's really a problem in knowing exactly where the money is going and into what specific things it's going to.

Because of these problems in tracking the funds, many schools are now moving toward mission-based budgeting, which more explicitly defines the time required for teaching and to identify the actual funding streams associated with their core missions. But until that is, I think sort of instituted in most schools we have a hard time with getting a handle on exactly how money is flowing and to exactly what extent.

To better understand the dependency of medical

schools on service-generated income and to try at least to disentangle some of how this money flows, we wanted to draw some comparisons between public and private schools because they differ somewhat in where they get their funding. Although there are more public than private schools, the private schools tend to be larger enterprises. Total revenues for public schools in '96-'97 averaged $239 million compared with $337 million for private schools.

So while we know the average amount of revenue generated by faculty practice plan is fairly substantial, we wanted to get a sense of the ranges. So based on the amount we looked at the share of revenues from faculty practice plans, hospitals in support of medical schools, and the total research grants for the 25th, 50th, and 75th percentile of schools. I'll probably refer to them as the bottom, middle, and top basically.

I'll walk you through what this graph actually means. I'll give you an example. But I think even before I walk you through it, there are probably two things that stand out almost immediately. Revenue from faculty practice plans have substantially increased between '87-'88 and '96-

'97. And the other important point, I think, on this slide is that revenue from faculty practice plans appear to be equally important for both public and private schools.

DR. WILENSKY: Where is the 75th?

MS. WALTER: The far right.

DR. WILENSKY: Where is the private?

MS. WALTER: Right here. I'll take the top 25 percent here of medical schools and you can see, of the public medical schools, derive 42 percent of their revenue from faculty practice plans right here. This is up sharply from nine years earlier.

For private schools -- and let me take another example at the 50th percentile here. For private schools, revenues from faculty practice plans constituted 36 percent or less for the middle half of the medical schools in '96-'97, and in '87-'88 they derived about 26 percent or less of their revenue from faculty practice plans. So that's sort of how we read this graph.

DR. MYERS: Isn't there a great deal of variance though, the ranges within public institutions of what they actually get from state government?

MS. WALTER: There is. That is the hugest difference between public and private is that, I believe, public get a lot of money from state --

DR. MYERS: No, within the public category, the University of X, which is a state institution, may get 5 percent from the state legislature, where the University of Y, which is a state institution, may get a great deal more. Did you look at the variance within the public category in terms of state support?

MS. WALTER: We didn't. We focused on these three, which would be the faculty practice plan, the hospitals, and the research.

DR. MYERS: Because I would hypothesize that many public institutions act, behave, look, and are budgeted, in many respects, the same as some private institutions. They don't look public with respect to their huge state subsidy.

MS. WALTER: I would probably agree with that. That's something we can look at, absolutely.

DR. ROWE: If you're going to pick one, pick Wisconsin.

MS. WALTER: Because of the confidentiality of

data, the AAMC provided us with this data. Based on our request, they did special runs for us. We're not allowed to look at the data specifically and any particular school. We're just allowed to get the aggregate data. So they do the data runs.

DR. WILENSKY: But we probably could get some variance measures, and we may be able to see whether we can get others. I agree, I think that to the extent we want to look at this issue, I think you'll find that it is probably highly correlated.

DR. ROWE: I think the variance -- I was going to make this comment later but it's relevant to this. I think when we started looking at the impact of changes on hospitals, the famous impact of the PPS margins, inpatient or total on hospitals, one of the ways we started looking at it was, what percent of hospitals will be negative? Rather than what the mean effect of hospitals was, and I think that's something MedPAC is doing pretty regularly.

I think the same argument holds here. Harvard Medical School, which is enormous, both in terms of its quality and in terms of its size and budget and endowment --

well over $1 billion -- has no clinical revenues essentially because it has these relationships with these hospitals. So it's going to be there with zero. And the Medicare number for Harvard is zero.

Then some other med schools have a very small, full-time faculty, as Bill was saying. The NYU School of Medicine has very small full-time faculty. Everybody's a volunteer. Others have almost entirely a full-time faculty.

One way to look at these data rather than this overall number and what percent Medicare is, is to see if you can get your colleagues from the AAMC to do some distributions to see what percent of medical schools have Medicare revenues over some percent. Maybe it would make more sense.

DR. WILENSKY: We were just laughing at the concept of Medicare-dependent medical schools.

[Laughter.]

DR. ROWE: But I'm trying to understand the dissonance between --

DR. WILENSKY: I agree.

DR. ROWE: You may get a bimodal distribution.

There's just something funny about this, that's all. It's worth looking at it from that point of view.

MS. WALTER: Sure.

DR. WILENSKY: And if your colleagues from the AAMC don't help you, we'll see whether Dr. Rowe can get his colleagues from the AAMC to.

MS. WALTER: They've been very receptive to everything we've asked.

DR. CURRERI: I think Jack really had a point. I've been at four different medical schools and almost certainly our Medicare revenue was about 20 percent of total revenues in the practice plan. So how that can get down to 4 percent on average --

DR. NEWHOUSE: Yes, 20 is the average overall --

DR. ROWE: It's 4 percent of the total med school. It's 12 percent of the faculty practice, but still seems to be like half of what it should be.

DR. CURRERI: It should be around 20 percent.

DR. ROWE: Why don't you do that, or ask them to do that? I think it would be interesting.

MS. WALTER: I will.

These next two slides are just showing, again, the differences by private and public for the hospital revenue. You can see here -- the only point I want to make really is that hospital revenue in support of the medical school is lower than it would be for faculty practice plan.

DR. ROWE: What's the denominator on the percent, hospital revenue percent? This is percent of total med school?

MS. WALTER: Yes. Revenues from hospital; hospital revenue.

DR. NEWHOUSE: And these percentiles are always Medicare percentiles.

DR. ROWE: So if GME comes into the hospital and goes to the med school it's included in that?

MS. WALTER: One would assume so. But again, there's so many problems in trying to figure out how money is flowing and where it's flowing to. But yes, that would be the assumption, is that there is some sort of subsidy or support. Again, this just looks at the research and grants.

I think that the most important point here is that we see revenues from research grants have declined slightly

between '87-'88 and '96-'97. Although it is important to note that total research revenues have significantly increased between this period. Now obviously, it's not shown on here but the total revenues from research have gone from $1.4 billion in '87 to $3.4 billion in '96 for private schools. For public schools it has increased from $1.3 billion to $2.9 billion.

DR. WILENSKY: But the other revenues have gone up faster, total revenues.

MS. WALTER: Correct.

DR. ROWE: This is the percent.

MS. WALTER: Absolutely; this is the percent. So we see that the percent has actually declined. But if we just thought about the amounts, they've actually increased.

My cursory review of the various Medicare changes and changes in other market conditions suggests that the impact on faculty practice plans will be minimal, and I want to go into a few of them. There are three changes that may potentially affect faculty practice plans revenues, and it's the three that I've highlighted up here. These changes relate to Part B of the Medicare program.

Physicians can bill under Part B when they personally provide services to Medicare beneficiaries, and in certain circumstances, when a resident provides services under the personal supervision of the teaching hospital. In terms of a shift to a single conversion factor, we think that it may actually increase faculty practice plan revenues.

The BBA required the implementation of a single conversion factor for all services provided under Medicare fee schedule in '98. This one-time shift to a single conversion factor is not likely to have a large effect on faculty practice plan revenues for several reasons. First, almost half of the clinical faculty in medical schools are primary care physicians and the single conversion factor actually increased payment rates for primary care services by 3 percent.

Now the conversion factor for surgical services did decrease by 10 percent. But surgeons comprise a relatively small percentage -- about 9 or 10 percent of all clinical factor. And the conversion factor grew by 8 percent for the non-surgical services often provided by the

specialists.

In terms of the resource-based practice expense payments, again, it's likely to have a minimal adverse effect on faculty practice plan revenues. The policy change will shift payments from procedures to visit services. So for example, when the resource-based system is fully phased in, general surgery will experience a 7 percent decrease in Medicare payments relative to the current practice expense system, and family practice will experience a 7 percent increase.

But it's important to note that the impact on the change of total revenue, Medicare, non-Medicare, for a given specialty will be less than the impact on Medicare payments alone because physicians also treat non-Medicare patients. And as I noted earlier, the share of faculty practice plan revenues derived from Medicare patients account for the 12 percent of the revenue.

In terms of the teaching physician rules, again, it's not likely to have any effect. The teaching physician rules replaced IL-372 and relate to the presence of a teaching physician to perform or observe the resident in a

key portion or any service or procedure in order to bill under Part B. Many in the academic community argue that the increased presence of teaching physicians for all procedures will leave less time for faculty to see other patients and reduce their billing submitted to Medicare.

We have also anecdotally that as a result of the PATH audits some physicians may have opted to sort of down-code, or in some cases we've also heard that physicians have been formally advised by their institution to down-code for their services, or even forgo billing altogether if they can't substantiate or clearly document their involvement in services performed by their residents.

Now the hard data suggests -- and it's only a few pieces -- but the physician payments under Part B account for less than one-quarter of the total estimated Medicare payments in '96. In a nationwide study of all program directors in internal medicine, which is the largest of the specialties, indicated that 50 percent of the programs will not be affected by this rule at all. And of the remaining half, about 20 percent of the program directors said that it will actually have a positive effect on teaching.

DR. MYERS: I hate to interrupt. You used a couple of terms interchangeably and I need to know, are we talking about revenue from Medicare patients, or revenue from the Medicare program? You said both in the presentation. A Medicare patient is a very different person in terms of revenue if she or he is at, for instance, Detroit Receiving Hospital compared to Beaumont Hospital, because of the various additional programs they may bring with them or their own ability to supplement what the program provides.

So what is the data that the AAMC is giving us? Which of those two is it?

MS. WALTER: The AAMC is giving us the revenues from the faculty practice plans for all medical schools.

DR. ROWE: That's Part B revenues. That's Medicare patients.

MS. WALTER: Yes, here I'm talking about Part B.

DR. MYERS: Just from the Medicare program, not any supplemental coverage from anything or anybody else.

DR. ROWE: Yes. And I think that's -- you know, if someone were to have asked me what the interdependence or

the dependence of medical schools on the Medicare program would have been, I would have talked about DSH and IME. I would have thought -- I wouldn't have gone to the faculty practice. Because it's the full-time faculty who take care of, in many institutions, the patients who represent the patients who are counted when one decides whether an institution is DSH-eligible, and who supervise the residents as part of their full-time job, and generate expenses that are included under IME.

So I would ask -- I think this is the same question Woody is asking. I would wonder whether you might consider, the staff might consider the possibility of including some statements with respect to that aspect. Now again, that will be very variable from one school to another, but I think it's one of the factors, or two of the factors.

MS. WALTER: Okay.

DR. CURRERI: I just want to point out, I think there's one real flaw in this analysis, and it's not something that you should have known about. But you're right, the way you've presented the data, what's happening

mostly in practice plans is you would expect to see a redistribution along departments as to earnings, but not very much effect on practice plans.

But that makes the assumption that all specialists by tradition work the same number of hours and see the same number of patients. In many medical schools -- not all -- many medical schools, the internists and the family practice people sometimes only do clinical work two months a year and the rest of the time is spent in research. And sometimes because of the large number of them, that they work evenings once every three weeks or four weeks.

Whereas the surgical practices, the tendency is to take very little regular time off for research and do it on the weekends and the evenings, and to be on call maybe every second or third night where you may be doing more operations through more hours.

So when you say you cut surgeons in a faculty practice plan by 7 percent, if they were providing 80 percent of the income, as it happens in some schools, which is then redistributed to the other departments, and the others don't take up that slack in terms of hours worked,

you may see a profound effect on the practice plan. And I think you have to somehow get a handle on hours per faculty member and how much they earn per hour, because there's a big difference in philosophy.

For instance, pediatricians generally don't work very long hours and they don't generally get paid very much because of the fact of the population.

MS. WALTER: Yes, I agree. We talked about looking at the averages per clinical faculty member and looking at those kinds of changes and increases. That is something we absolutely have to do.

DR. WILENSKY: But it would be --

DR. CURRERI: Let me give you just an example.

DR. WILENSKY: I understand the issue that you're raising. The reason this would be important for us is because you think that there have been changed in the last decade and there are likely to be further changes in the next decade. To the extent that what you say is true but it remained more or less the same, I'm not sure it affects our analysis. To the extent that you're having a different mix of participation by the internists or the pediatricians or

the surgeons, then it would affect --

DR. CURRERI: No, I'm saying that the shift in terms of income to the practice plan from surgical services to non-surgical services is likely to result in a net decrease in total revenues because of different work ethic and different ways that they approach academia.

DR. WILENSKY: And you think that whatever shift has gone on in the last decade, you think it will be a continuing -- what I'm really thinking about is sort of the difference is not that --

DR. CURRERI: Yes, and practice expense is going to add it on again.

DR. ROSS: But by a shift, Bill's referring to the conversion factor shift and the different weights.

MS. WALTER: Right. He's saying that there may --

DR. ROSS: It's not the mix of physicians in a practice plan.

DR. CURRERI: No, the mix will stay the same. It's just the difference in --

MR. GUTERMAN: So you're talking about, when Deborah said that 49 percent of faculty were primary care

physicians, that it's not 49 percent of the revenue from primary care --

DR. CURRERI: And it's not 40 percent of the time commitment.

MS. WALTER: You're saying one person, who could be a surgeon possibly, is supporting almost the whole team.

DR. LEWERS: That's when you've gone too far.

[Laughter.]

DR. CURRERI: Let me tell you, it is not uncommon in practice plans, if you take all the surgical specialties, produce twice or three times the income of all the rest of the non-surgical specialties.

MR. GUTERMAN: So it's revenue-weighted.

DR. CURRERI: That's right.

DR. ROWE: Deborah, just quickly. So with respect, my estimate would be, or a way to look at it would be, when you're trying to figure out what the Medicare funding of medical schools is -- and it may not be a big number and it may be very variable -- you would add that percent that you get from the faculty practice to whatever proportion of that hospital support is estimated to come

from DSH and GME, or something like that, or IME. That would be the Medicare funds that come to the hospital that the hospital turns and pays --

MR. GUTERMAN: We'll have to look at that. I'm not sure, that may be in the 40 percent other. We don't know.

MS. WALTER: We don't know.

DR. ROWE: That's right, it may be. But I think that would be fair.

The other thing, just from completeness, when you talk about -- and this has got nothing to do with Medicare, per se -- the impact of faculty practices on medical schools', creditworthiness is a very important thing. When a medical school goes to borrow money, if the faculty practice revenue stream is in the medical school and not in a separate entity, that has a big impact on its borrowing power. You know, when bond-rating agencies, et cetera, come along. And it turns out to be a structural reason to include faculty practices.

DR. WILENSKY: Big positive impact.

DR. ROWE: Positive, yes.

MS. WALTER: So it's getting into that capital and all of those kinds of issues.

Very briefly, I'm just going to talk about the research and sort of the managed care areas. Without adequate research funding from external sources, research efforts become more heavily reliant on clinical earnings, as I alluded to earlier. Some have argued that demands on discretionary revenues available from clinical practice needed to support the research enterprises in medical schools are escalating due to recent policy changes limiting reimbursement of certain research costs on federal grants, the increase in competition for research funds, and requirements by federal agencies for greater institutional sharing.

But the perceived threat that revenues from faculty practice plans may have to increasingly support research is somewhat moderated by the Administration's recent announcement which increases the NIH budget by $1.15 billion -- that's about 8.4 percent -- over fiscal year '98 appropriation, bringing the total budget to $14.8 billion for '99. This proposal is part of a plan to increase the

NIH budget by $20 billion by fiscal year 2003, and that represents a 46 percent increase over the next five years.

Just briefly on a last point in terms of managed care. Obviously, it requires continued monitoring, but we have a sense that there will be an adverse effect on faculty practice plan revenues. One study suggests that since '91, medical schools located in high managed care areas have experienced decline in their faculty practice plan revenues per clinical faculty compared to medical schools in lowest areas of penetration.

Another recent study that has come out has suggested that medical schools in markets with high managed care penetration has slower growth in the dollar amounts and number of NIH awards compared to schools in markets with lower median managed care.

That's all I have.

DR. WILENSKY: Let me open it up for questions among the commissioners. I just want to be sure you understand, the reason this is particularly an area that is included within the scope of our GME is that it is specifically in the legislation.

DR. ROWE: It's required in the BBA.

DR. WILENSKY: Right.

MR. SHEA: Have you calculated or made some attempt to estimate what the increase in NIH funding, if it follows the projected path, would mean for medical schools?

MS. WALTER: I'm sorry, I don't understand.

MR. SHEA: If they really do go to $20 billion in NIH budget, what is that going to mean for the medical school income, based on what they've gotten in the past?

MS. WALTER: Medical schools historically have gotten 50 percent of all NIH monies, extramural NIH funding. So when I talked to the NIH folks -- I mean, we don't anticipate that that's going to change. That 50 percent is still going to -- they're still going to probably receive --

MR. SHEA: Do you know what the NIH budget was before they started this big run-up?

MS. WALTER: It's gone up by 1.1, so let me see here. It had to have been, I guess about $13 billion, because it's gone up by $1.15 billion over last year.

MS. SHEA: So presumably this might mean another, in the range of $3 billion to $4 billion for medical

schools?

MS. WALTER: It's a lot.

DR. WILENSKY: Any further questions?

MR. SHEA: A lot of people wish they were getting those kind of increases.

MR. GUTERMAN: And those funds are very heavily concentrated, too.

MS. WALTER: Right. They're concentrated in sort of a third of the schools. I mean, they're heavily concentrated in the top 20.

DR. WILENSKY: Thank you. Interesting presentation.

Let me open it up to the public for comment, either on renal dialysis or on this GME presentation. I apologize for lumping them together, but I was interested in having as many commissioners hear as much of this as possible before they left. And Judy and Craig, thank you for your indulgence in being pushed off till next time.

MR. AHOE: I've got a quick comment. My name is David Ahoe. I represent a small start-up dialysis company by the name of Access. I sort of feel like the House

managers of the impeachment inquiry: you need to hear from the witnesses, and my witness just left on a plane back to his board meeting that he had to get to. So I apologize, but you will get a letter from him directly.

I think it's important to assess two issues that were brought up, and that is assessing the entrance into the marketplace somehow reflecting the fact that there are sufficient funds for dialysis. Dana's report was quite good, but she responded quite honestly to your question about new technologies: there aren't any. I wish Dr. Lewers was here to correct me if I'm wrong, but there truly aren't any.

This is a new technology that's trying to get into the marketplace, and the gentleman that was going to testify or the gentleman that was going to make a presentation by the name of Lawrence Kinnett who's chairman and CEO of this company. The other thing he was going to respond to was a question that was raised I think by Mr. MacBain two sessions ago and that was, if outcomes are better in the international arena, then is the payment structure different to reflect those better outcomes?

What Mr. Kinnett was going to share with you were the outcomes in Japan are significantly better than the rest of the world, and their payment structure, which will be included in the letter, is almost double for one extra hour of treatment, which speaks to the fact that they truly feel that more time on analysis would reflect better outcomes. And the same holds true for a French example, and an Italian example that he was going to share with you that he will, again, send in the letter.

So I thank you for your time. But I truly think one should look at what new technologies have been introduced in this interim period. And the Congress -- I personally delivered your recommendations over the last three years, and they've been received with a yawn, I'm sorry to say that. There has to be some sort of crisis related to this recommendation to get some movement, because there's enough on their plates.

Thank you.

DR. WILENSKY: We'll certainly look forward to receiving the information. The two issues I think that are of particular interest is the payment and any relationship

that can be discerned to outcome.

But the other is the health status or health conditions of the patients being dialyzed, because one of the issues that we will have to account for in assessing higher mortality in the U.S. is that we are much more aggressive in dialyzing patients than other countries. And it's not to take away what additional payment, producing additional dialysis time, might mean.

But nonetheless, we do have to account for the fact that the kinds of patients that are dialyzed in the U.S. are, I believe, very different in terms of both age and illness characteristics than people who are being dialyzed, and to make sure we understand which of these effects are causing or are associated with the difference in outcome. Any information you can share on those issues in other countries would help us. We can get the data on the U.S.

MR. AHOE: One last thing, if I may, just when Dr. Lewers is here. The CCPD was given a 30 percent premium in 1989. It has now barely reached 5 percent diffusion. In order to show up on your ST&A, you have to reach 5 percent diffusion. So a technology in dialysis that had a 30

percent premium would never meet your standards. So they're in a little bit of a box here. It's a proverbial box.

If he disagrees with me, I'd love to hear the difference. Thank you.

DR. WILENSKY: Any other comments?

MR. DICKLER: Madam Chair, I'm Bob Dickler from the AAMC. The hour is late. We will work with staff to try and clarify a number of the questions that were raised here. I think the only comment I'd make specifically is in the context of service dependency it's useful to think of the faculty practice and the hospital dollars combined because those are all driven by the service delivery system, which really brings us to about 50 percent of medical school expenditures being driven by the service side of the activity of the medical school and their partners.

But with that, let me say, we'll work with the staff and try and clarify everything that was raised.

DR. WILENSKY: Thank you very much. We appreciate the offer of help.

This has been a long and very substantive two days. Thank you to the people who have been listening and

interested in these issues. Special thanks to the staff at MedPAC who have worked so hard to produce the information, and will work hard yet again to get it out for our March 1st delivery of a report to Congress. We will be meeting next on March 18th and 19th at the Embassy Suites. It will be on our web site and the agenda will be mailed out.

Thank you for your attendance.

[Whereupon, at 3:16 p.m., the meeting was concluded.]