# MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

**Thursday, December 4, 2003**
**10:13 a.m.***

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
NANCY-ANN DePARLE
DAVID F. DURENBERGER
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

***The December 5th proceedings begin on page 280**

AGENDA PAGE

Dialysis services: assessing payment adequacy and updating payments -- Nancy Ray 5

Medicare+Choice payment policy -- Scott Harrison, Dan Zabinski, Karen Milgate 58

Public comment 100

Physician services: assessing payment adequacy and updating payments -- Cristina Boccuti, Kevin Hayes 112

Home health: assessing payment adequacy and updating payments -- Sharon Cheng 157

Hospitals:
Inpatient and outpatient services: assessing payment adequacy and updating payments -- Jack Ashby, David Glass, Chantal Worzala 199

Outpatient PPS; outlier and transitional corridor payments -- Chantal Worzala 238

Public comment 267

**Note: The December 5th proceedings begin on page 280**

P R O C E E D I N G S

MR. HACKBARTH: I'd like to welcome our audience. Please take your seats.

Let me make a few comments to help set the stage for today's and tomorrow's session. As you may have heard, there have been some significant legislative developments in the Medicare program recently, so recently in fact that it poses a challenge to the Commission on how to proceed with its work.

Obviously, the legislation has very large impacts on the program, including some of the issues on our immediate agenda. So let me try to explain how we're going to deal with that.

First of all, we will not be addressing the Medicare reform legislation in its entirety in this year's reports. At some point in the next year we will try to put out a document that explains some of the issues that we think arise for the program and for the Commission out of the legislation and will serve as a bridge, if you will, to our work in the next cycle beginning in the fall of 2004.

Having said that, pursuant to our existing mandate we need to take up a number of specific provisions in the

legislation just to complete our normal cycle of work for this year. As we do that, we will reflect the reform legislation in some important respects, one of those being as we address -- make recommendations about the appropriate updates for the various provider sectors, the analysis that will be presented by staff over the next couple days will include the impact of the reform legislation.

So this month and next month we are making recommendations for fiscal year 2005. As you hear the staff discuss financial analysis, that analysis will include the impact of all of the legislative provisions affecting updates through 2004 and all of the distributive -- what we refer to as distributive provisions that affect, for example, rural hospitals differentially than urban hospitals, all of those that are scheduled to be accompanied through 2005. The one piece and will be omitted from that staff analysis is the legislated update for 2005. And the reason, of course, that's the questionable before the Commission, so we don't include that.

In keeping with our approach of last year, the staff will be presenting a series of draft recommendations on update factors and a variety of other issues. Those are

draft recommendations that I have developed along with the staff. They are a starting point for the discussion of the recommendations. They are not an end point, but they are draft recommendations that I have developed.

I think those are the key points to get us started. The first item on our agenda for today is dialysis services. Nancy.

MS. RAY: Thank you, Glenn.

Recall that our update framework first considers the question of whether current Medicare payments are adequate and then considers the second question of whether payments should change in 2005, the next payment year. So let's proceed and try to answer these two questions for outpatient dialysis services.

To assist payment adequacy, your mailing material includes an analysis of six factors. Some are beneficiary focused and some are provider- focused.

The first factor we looked at is beneficiaries' access to care. Here the evidence suggests that beneficiaries are not facing systematic barriers in obtaining needed care. Throughout the year, we monitor the literature, dialysis magazines, and Internet websites to

look at any potential access barriers that may be coming along during the year.

For this year we particularly -- some have raised concerns that facilities may be exiting areas that are located -- facilities located in lower income areas. So we took a look at that this year. What we found is that this does not appear to be the case. The two biggest factors that seem to reflect closures are whether the facility is non-profit and whether the facility is hospital-based. We looked at the proportion of facilities remaining open in HPSAs and there was very little difference, in rural areas very little difference, and we also looked at --

DR. NEWHOUSE: [off microphone.] What exactly does this mean? Does this mean that 50 percent of the hospital-based facilities closed in a year?

MS. RAY: No. This means that of the facilities that closed.

DR. NEWHOUSE: All right.

MS. RAY: The fact that we found that the non-profit and hospital-based are more likely to close is consistent with our analyses that we have conducted last year and the year before last. What makes this analysis

different is that we looked at whether or not the facility was located in a HPSA. We've looked at the proportion of facilities in rural areas and that has remained constant. Roughly 25 percent of all facilities are in rural areas over the last five years.

This is the additional new information that we looked at this year, looking at the facilities that opened that remained in business versus those that closed. Again, we see very little difference based for lower income areas and areas based on ethnicity and race.

Moving right along now to the second factor, we looked at providers' capacity to treat patients. And here we conclude that capacity appears to meet demand. This graph compares the growth in the number of in-center dialysis hemodialysis stations to the growth in the patient population.

Our framework, or the third factor that we looked at the growth of the volume of services. Here increasing volume of services could suggest that payments are at least adequate.

With that in mind, total dialysis patients have been increasing by about 6 percent per year between 1996 and

2001. Dialysis payments have also increased by 6 percent per year during this time period, from $2.4 billion to $3.3 billion. Separately billable drugs, erythropoietin has increased roughly about 12 percent from $809 million to $1.4 billion. And other injectable drugs show the greatest growth, growing by about 25 percent per year from $281 million to $877 million.

Moving along now to our fourth factor that we looked at to assess payment adequacy, we looked at quality. It's continuing to improve for some measures. We used CMS's clinical performance measures that show improving dialysis adequacy, improving anemia status. Again, for dialysis adequacy and anemia status as well as nutritional status, we have data now going back from 1993.

There has been little change in beneficiaries nutritional status and this focuses -- this is partly due to CMS's coverage policy on some of the nutritional interventions. They have a restrictive coverage policy for the use of those interventions.

Finally, CMS is now starting to collect clinical performance measure data on vascular access care. There was some small improvement in vascular access care, and my

understanding is that the networks -- that's the QIOs -- for dialysis facilities are engaging in a quality improvement project aimed to improve vascular access care.

Many may be aware of a recent GAO study that discussed dialysis quality. It was released last month. And the GAO study focused on quality assurance; that is how well facilities are meeting Medicare's conditions of coverage. The conditions of coverage are Medicare's baseline standards, quality standards. It also commented on how well CMS and the states are conducting their survey efforts.

GAO raised concerns for all three parties, facilities, the CMS, and the states. And in fact, made six recommendations to improve the quality assurance process, three of which MedPAC made back in June of 2000. Those three were to improve the frequency of inspection, to implement intermediate sanctions, and to publicly release the results of the survey and certification efforts on the publicly available Dialysis Compare website.

At the end of my presentation, I'd like to come back to quality and talk about other ways for Medicare to consider to improve dialysis quality.

This leads us to the fifth factor, access to capital. Access to capital appears to be sufficient. We base this on the reports from financial analysts and we also base this on the growth over the last 10 years of for-profit facilities. It seems to be still an attractive place for for-profit facilities to build facilities as well as acquire existing facilities.

With that in mind, one of the four major chains just announced on Monday their intent to acquire non-profit facilities in the Midwest, picking up about 260 patients.

DR. ROWE: [off microphone.] Nancy, while you're on that point, could you indicate whether this growth in for-profit facilities has been largely conversion of not-for-profits, or is this establishment of new facilities?

MS. RAY: That's a good question.

DR. ROWE: [off microphone.] Because many hospitals find that it makes more sense for them to basically sell their facility to a for-profit and then management has a lower cost of goods, established management programs, as long as the hospital's patients have access and doctors have access. And then the place has access to capital and it can renovate because the hospital hasn't been

able to renovate the dialysis unit because it doesn't have any access to capital, et cetera, et cetera.

So I was just wondering about that conversion.

DR. MILLER: [off microphone.] Nancy, I thought we had some discussion of this at one point when we were talking some of the language in the report. I was asking a question about growth at the expense of.

MS. RAY: Yes, I do remember that discussion. Yes.

DR. MILLER: I don't know if it's was a one for one, but I thought you said at that time that the growth for the non-profits is definitely --

MS. RAY: Right. Clearly, some of the growth of for-profits has been those chains acquiring non-profit, independent non-profit and hospital-based facilities.

DR. ROWE: [off microphone.] Like you said, in the Midwest.

MS. RAY: Right, exactly. What I can't give you right now is the exact number, the exact proportion, whether it's half new facilities and half acquiring old. I'll have to get back to you with that.

DR. ROWE: [off microphone.] I think it would be

interesting because one of the measures we use of access is whether there's new entrance into the market place in terms of new facilities and access to capital.

DR. REISCHAUER: But we know that there are new facilities because there's been tremendous growth in the number of facilities.

MS. RAY: And facilities. There has been a net increase.

DR. REISCHAUER: I'm looking at the paper that says facilities and there's been a 76 percent growth over the last decade, so that's not chicken feed.

DR. ROWE: [off microphone.] Right. I accept that. I was thinking over the last couple years is whether it's gotten to steady state or whether it's continuing to increase. That was my question.

DR. REISCHAUER: But if we know that the total number of facilities is growing or stations, or whatever we want to measure it by, is growing along with the demand, then do we care about the composition?

DR. ROWE: [off microphone.] No, I don't think we care from a policy point of view.

DR. REISCHAUER: For business opportunities.

DR. ROWE: [off microphone.] No. No. Sorry to interrupt. More sorry that you know.

MS. RAY: Not a problem.

So moving right along, that was our fifth factor, access to capital. And that leads us to our final factor, payments and costs for 2004.

Let's take a minute and talk about this graph. First of all, you'll see that we have three years of data reported here, 1999, 2000, and 2001. We unfortunately don't have 2002 data to show you, and that is because we had a very small sample, we have a very small sample right now of cost reports in the data that CMS makes available. Roughly we only have 40 percent of facilities cost reports in 2002. That compares to about 91 percent in 2001. So that is why we don't have the more recent year available. Hopefully, there will be one more update to CMS's database on cost reports and who know, maybe we'll get lucky.

Next, you'll notice that there's two lines, red line and a yellow line. As you recall from last year, we analyzed 1996 cost reports. In 1996 the FIs did an extensive audit of the cost reports of freestanding dialysis facilities. Roughly about two-thirds of the cost reports

were reopened and settled with an audit.

So the red line reflects adjusting cost to reflect the results of the audit. Overall, what we found in comparing 1996 costs from cost reports before they were audited to after is that reported costs were roughly 96 percent of allowed cost. So what we did here is we adjusted cost to reflect the 96 percent that was allowable, payment-to-cost ratio. So what you're doing is you're reducing the denominator that will increase your payment-to-cost ratio.

So the red line includes the audit adjustment and the yellow line does not include the audit adjustment for each of the three years that we have presented.

Also recall, we did this audit adjustment last year and ProPAC, many years ago, also did an audit adjustment back in the late '80s. There they found that reported costs were 88 percent of allowable cost back then, from the late '80s.

So here you'll see a payment-to-cost ratio in 2001 of 1.03. That's without the audit adjustment. That's roughly, for you margin people, a 1.8 percent margin. And including the audit adjustment, the payment-to-cost ratio is 1.06, which is a 4.4 percent margin.

I'd like to talk about the downward trend between 1999 and 2001 and what explains this trend. Payment was increased in 2000 and 2001 by 1.2 percent and 2.4 percent. But at the same time, Amgen raised the price of erythropoietin by 3.9 percent in each of those two years.

In addition to that, providers costs spiked, particularly between 2000 and 2001, by 5.5 percent. The two areas that rose were labor costs and the administrative and general costs that are reported on the cost reports.

DR. ROWE: [off microphone.] And labor costs were mainly nursing costs?

MS. RAY: The labor costs reflect nurses, technicians, LPNs, dietitians, as best of my understanding. It includes salaries and it includes benefits.

DR. ROWE: [off microphone.] You don't know where the increase is?

MS. RAY: No, it does not break it out by the specific labor component, no. It's just the one category. Unfortunately, we don't have a break-out for the administrative and general expenses, either. My impression from the industry is that some of that cost growth was due to liability increases and malpractice increases there, as

well as utilities.

So estimating from the 2001 point -- I guess I'd like to make the point that I presented payment-to-cost ratios and I'm also presenting margins to be consistent with the other sectors, for example, in the hospitals and SNFs and home health you usually hear margins not payment-to-cost ratios. And a margin, just for the audience's sake, is payments minus cost divided by payments, which is roughly the percent of revenue the provider is keeping, our rough estimate of that.

MS. DePARLE: And it's just Medicare?

MS. RAY: It is just Medicare.

DR. REISCHAUER: Nancy, what was the takeaway from your description of what happened between 1999 and 2001, but looking out into the future? That you think these payment-to-cost ratios are going to level off?

MS. RAY: Okay, that leads me to my next point.

DR. REISCHAUER: Okay, I'm your straight guy.

MS. RAY: Thank you.

So what we did is we took our 2001 point and we proceeded then to estimate 2004 payments and cost. We do that by inflating costs by the market basket. The payment-

to-cost ratio then, including the audit adjustment, for 2004 would be 1.02. That would be our estimate. That represents a 0.7 percent margin. So this presumes continued increases in cost based on the market basket, if that answers your question.

MR. MULLER: Along the line of Bob's question, I seem to remember two years ago we were looking at cost estimates that people were saying the costs were going up beyond the marketplace indicators that we had. So this would kind of confirm that the way the costs finally came in, it came in above the estimates that we were making at that time of what the costs would be. Is that fair? That the actual costs, now that we've seen them two years later, are higher than the costs that we had anticipated at that time?

MS. RAY: It's your question are the actual costs higher than the market basket? Than the Commission's market basket estimates in previous years?

MR. MULLER: That's another way of saying that, yes.

MR. HACKBARTH: Another way, perhaps of asking it is if we went back and look at what we projected for this

year, how did our projection for 2001 compare with the actual result? Now that we have real data.

MS. RAY: I would like to get back to you on that, if I could.

MR. HACKBARTH: In rolling forward from the actual data, you said you used market basket or was it market basket minus a productivity factor.

MS. RAY: Market basket less a productivity, yes. Thank you for the clarification.

MS. DePARLE: And when you say market basket, there's a CMS market basket and then --

MS. RAY: Right, exactly.

MS. DePARLE: I've never understood why we have a separate one? Why we don't just agree with CMS.

MS. RAY: We had a separate one because CMS just developed their market basket for dialysis services. It was just released in May of this year.

MS. DePARLE: So we had one before.

MS. RAY: Ours is first.

DR. REISCHAUER: [off microphone.] The question is why did they have one?

MS. DePARLE: They were told to develop one. So

what are we going to do? Are we going to use theirs or are we going to use ours?

MS. RAY: I was going to talk about that later but let me go ahead and address it. First of all, if you use CMS's market basket to project out costs to 2004, just to let you know that the payment-to-cost ratio in 2004 would be estimated at 1.01. That's the first thing.

I think the second thing is, of course the Commission can talk about whether or not to just go ahead and adopt the CMS market basket or we can continue to use both and compare the two. BIPA required the Secretary to develop the market basket for dialysis services.

I think over time, as CMS goes to a broader bundle, and then the market basket is going to have to be revised to account for those additional services, that might be one factor in leading us to think about using the CMS market basket.

Your mailing materials included some historical data in how well CMS's market basket compared to MedPAC's. Both are pretty close, but we can talk about this a little bit later.

DR. REISCHAUER: They aren't as close as the table

suggests though, because you have the MedPAC market basket in every year rising faster than the CMS market basket. And yet, averaged over a five year period, they are the same. There must be a typo in the table.

MS. DePARLE: I'd be interested in qualitatively can you describe what the differences are and why we would choose ours versus theirs.

MS. RAY: Sure. The differences are when ProPAC first developed the Commission's market basket, they used indices from the home health, SNF, and hospital PPS market baskets.

So for example, the easiest example I can give you is in the MedPAC market basket there are four main categories: labor, other direct costs, capital, and administrative and general. For the labor component, what is used is they used the home health labor index, they use the SNF labor index, and they use the hospital PPS labor index. And each is weighted by one-third.

So it's a mixture of -- for the other categories it's a little bit more complex, but it's a mix of the use of utilities from SNFs and so forth, to come up with the Commission's market basket.

CMS, on the other hand, uses eight categories, not four, I believe. And they pull out the indices from either using the ECI, the PPI, and I'm sorry, I forget the third one. So they're using, for example, the labor -- to estimate the labor costs for all health care workers from the ECI, for example.

I can get back to you in the January mailing materials with more detail about the comparison of the two, that will help you think about this issue more closely.

DR. NELSON: Nancy, what are the implications of the consistent difference between audited and unaudited?

MS. RAY: Excuse me, I'm sorry?

DR. NELSON: What are the implications of that consistent difference, between audited and unaudited? What does that mean?

MS. RAY: What we did in each year, in 1996 we found that the reported costs that facilities put down on their cost reports once they were audited, that CMS disallowed basically 4 percent. So reported costs were 96 percent of allowed cost.

So what I've done here is made an adjustment to cost in each of the years, taking roughly 96 percent in each

of the years. So that's why between the two lines there's that same three percentage point difference.

DR. ROWE: [off microphone.] It's not a typical accounting audit. It's a revision of what's acceptable.

DR. NELSON: I got it. Was the standard of variation pretty narrow or pretty broad? This is a consistent number that represents the difference. And I guess I would ask whether or not there were a substantial number of outliers in which that difference was much different from the average?

MS. RAY: I can't answer that question for you right now. But what I can answer is that about two-thirds of facilities had a substantial decline from their reported costs to their allowable costs. I'd have to get back to you to answer your more detailed question.

MR. HACKBARTH: We're doing an excellent job of anticipating issues, some of which I think are planned for later parts of Nancy's presentation. Could I suggest that we let her get her presentation out and then we'll take commissioner questions? I think that will be a more efficient way to proceed. So why don't you go ahead, Nancy.

MS. RAY: I think we're finished with this chart.

So just in summary, the analysis, just a gentle reminder of the first five market factors suggest no systematic problems in accessing care, that there is sufficient capacity to treat patients, and services are growing. There is improving quality on some measures and providers seem to have sufficient access to capital.

That leads us to the second part of our update framework, looking at what kind of cost changes can we expect in 2005.

Here again, the one major factor that we consider is the change in input prices between 2004 and 2005. As we've already discussed, we now have two market baskets, Commission's and CMS's. The Commission's market basket estimates the increase in providers costs at 2.3 percent. CMS estimates that cost growth to be 2.9 percent.

We also look at other factors that may affect providers costs between 2004 and 2005. One of those is cost increasing and quality enhancing medical advances. Here, based on our review of the literature, we believe that most of these advances will come in the way of separately billable drugs.

And then find that the other factor that we do

consider is the productivity growth. Our update framework reflects our expectation that, in the aggregate, providers should be able to reduce the quantity of inputs required to produce a unit of service while maintaining service quality. We use a 10-year economy-wide multi-factor productivity growth and that is currently estimated at 0.9 percent.

So putting together the increase in input prices less the adjustment for productivity improvement, that would result, using MedPAC's market basket, in a 1.4 percent increase to the payment rate for the composite rate services. Using CMS's market basket, that would result in a 2 percent increase.

As a reminder, current law increases composite rate payments in calendar year 2005 right in the middle, by 1.6 percent.

So that leads us to our first draft recommendation, that the Congress should maintain current law and update the composite rate by 1.6 percent for calendar year 2005. The spending implications of this are none, because it's already in current law. And for beneficiary and providers it would increase the composite rate for providers. And for beneficiaries, maintain access

to quality care.

MR. HACKBARTH: For the benefit of the audience, I should say that although we will discuss draft recommendation at this meeting, the actual voting on recommendations occurs in January.

Any questions or comments?

MR. MULLER: If we can go back to your slopes of the payment of costs. I noticed in the material you sent out ahead of time that it looks like the costs in 2000, which is the last year that we have the costs on, went up about 5.5 percent over the year before. Our market basket index was about 3.8, so about one-half higher.

If that is likely to occur in '02 as well, because a lot of things were going on in '01 in terms of staff shortages, nurses, et cetera, blood costs, those kind of things that were probably still going on in '02.

Does that mean is it likely that as we get the '02 and '03 final estimates, that we're likely to be below 100 percent of payment-to-cost?

MS. RAY: Again, without a larger sample of facilities with cost reports for 2002, I just don't -- you know, at this point can't estimate what the change -- how

the slope of costs will go.

MR. HACKBARTH: Can I ask a related question? Earlier you gave us a projection of the margins for '04, and it was less than 1 percent, .7 percent or something like that.

MS. RAY: Right.

MR. HACKBARTH: That involves a projection of costs and revenues out into the future. On the revenue side, is the assumption just the increases in the composite rate? Or how do you factor in the growth and the use of the drugs outside the composite rate? Since that's a big part of the profitability of the business.

MS. RAY: Sure, absolutely. That's a good question.

That's where our estimate, I think, conservatively estimates what the payment-to-cost ratio is in 2004, because we don't adjust for the increasing volume of separately billable services, which as you've already seen has gone up considerably since 1996.

DR. REISCHAUER: That's 40 percent of the total, if I remember your analysis.

MS. RAY: That's 40 percent of the total, that's

right.

DR. REISCHAUER: And we're saying that it doesn't change.

MS. RAY: And it doesn't change, that's right. If you think it would change -- if you wanted to increase it between 2001 to 2004 based on the annual growth rate, it would be roughly probably increasing the proportion from 40 to roughly 43 or 44 percent of payments.

DR. REISCHAUER: But there's a huge margin, we think, on that.

MS. RAY: There is a large and positive margin on that, yes.

DR. REISCHAUER: So it affects really the way we view this whole thing but we aren't making a guesstimate of how much.

MS. RAY: I could go back and do that.

DR. REISCHAUER: No, I'm just reflecting on how worried should we be about this downward sloping line. And the answer is not as much as one would think.

MS. RAY: Right, because we hold volume of services constant, this is -- like I said -- a conservative estimate.

MR. HACKBARTH: I think it would be helpful if fore the January discussion we could have a sensitivity analysis or something that shows the revenue side, which might be changing there, as well as the issue raised by Ralph about the trend on the cost side.

MR. MULLER: If we're doing our two-stage test and let's say if the costs, in fact, are accelerating more than our past indices, it's likely that we might be below the payments on this before the drug analysis that Bob has asked for, that we may -- if the payment ratio is less than 100 percent, then the question is does that kind of touch the question of adequacy or not?

MR. HACKBARTH: In fact, if we just look at the composite rate services only, the ones covered by the composite rate, I think we're already below 100 percent.

MS. RAY: Yes, you are.

MR. HACKBARTH: That is offset by the very substantial profits earned on the non-covered, or the services outside the composite rate.

MS. RAY: That's correct.

MR. HACKBARTH: That's the piece that's been growing. So understanding that part of the projection, I

think, is as important as understanding the cost trend.

Other questions or comments?

DR. WOLTER: I was just looking at the data on Table 3 that had some things like sessions per station, total treatments per employee, percentage of LPNs, percentage of RNs. And I'm thinking about this productivity adjustment which I know is a discussion point right now, not only in dialysis but in other sectors.

Those would possibly be some indicators, perhaps not outstanding ones, but some indicators of is there in fact some track record of productivity increases. And I'm wondering if dialysis would be a place to start looking from year to year at some indicators that might help us understand, in fact, are productivity changes from year to year current because I think there's some controversy about that issue and how easy is it to do.

In this particular set of data, if you look from 2000 to 2002, there are a couple of things there that in a high-level way might suggest some productivity improvements although 2001 went in the other direction.

It's just a thought.

MR. MULLER: Triggered by Nick's comment, dialysis

is always more of a focused factor than probably other things we look at. So insofar as some people have been touting that as a way of getting more productivity in health care. It would be useful to try to take a crack at Nick's question.

MS. DePARLE: At one of our last sessions, when we talked about this, we spent some time talking about the medical interventions, and I remember specifically nutrition, that were not covered by composite rate. And I was persuaded that we should try to do something about that.

DR. ROWE: I think we're going to get to that.

MS. DePARLE: Am I jumping ahead again?

DR. ROWE: We're going to get to rewarding quality based on these measures in the next presentation.

MS. DePARLE: Good, I hope we will.

DR. REISCHAUER: I think Nick's focus is an interesting one and I glanced at that table and thought whoa, not much productivity here. But then I looked at treatments per employee, which would be a crude measure. And it actually increased by 3.9 percent over the two-year period. In other words, well above -- we're using total factors as opposed to labor factor productivity.

But also, one wonders when we're considering productivity in this sector, what is the appropriate measure of output? And it's quality adjust treatments. And we have some measures that quality has improved.

Of course, we want to reward people for that improvement in quality. We don't want to take away from them, in a sense. So it's a complex issue, I think, for us to grapple with because what we want is to provide the best care that's available at reasonable prices.

MS. RAY: Right.

MR. HACKBARTH: We've had several comments raising, I think, important and very legitimate concerns about are we perhaps being too aggressive here in light of the cost trends and declining margin and the like.

The other piece of the picture, or another piece of the picture, is that when we do our analysis of adequacy we don't look only at margins. Here we have an industry where there seems to be a continuing influx of investment by for-profit companies that presumably see this as a good business opportunity. So it's a complex picture.

Do we want to move on to the other recommendation, Nancy?

MS. RAY: Yes.

I promised earlier that we'd be drilling down a little bit more about quality of care. As I've already discussed, GAO and patient organizations continue to raise concerns about dialysis quality.

Recall that Medicare right now uses I would say three levers to try to maintain and improve quality. One, the quality assurance standards. Two, quality improvement efforts undertaken by the networks. And three, the publicly reporting of data both on the Dialysis Compare website, which is a facility level website that provides outcome information by facility, as well as CMS's clinical performance measure project.

I would suggest that there may be a fourth lever for Medicare to think about to try to improve quality, and that would be using quality incentives to improve outpatient dialysis care. Recall that the Commission expressed an urgent need to improve quality in our June 2003 report and endorsed the idea of the use of linking payments to quality. The outpatient dialysis sector is a ready environment for doing so.

In the June of 2003 chapter, the Commission

included four criteria to think about using quality incentives for a given sector. The first criteria: are there evidence-based measures available. The answer to that for dialysis services is yes. The National Kidney Foundation has spent many years in developing evidence-based measures with providers, facilities, physicians and nephrology nurses, and we have evidence-based measures for, of course, dialysis adequacy, anemia status, vascular access management, nutritional management, as well as a new one related to bone disease.

The second criteria questions whether providers can improve upon these measures. Again, I think the answer to than for outpatient dialysis sector is yes. Since 1993 we've seen that providers can improve upon dialysis adequacy and anemia status. More remains for those two indicators and now there's new indicators related to bone disease as well as nutritional management.

The third question is are there data available to risk adjust measures? Here again, the answer is yes. When a patient first becomes eligible for the ESRD program, the facility is required to fill out a medical enrollment form the 2728 form. Here we have comorbidities at ESRD

incidents. And those data are collected electronically and maintained in a nice computer database. We also, of course, have access to all beneficiaries' Part A and Part B claims to supplement the medical evidence data.

And then the fourth question is are there systems in place to collect data? And again, here the answer is yes. Right now CMS collects adequacy of dialysis information and hematocrit status on facilities outpatient dialysis claims, on the claims submitted by outpatient dialysis facilities for dialysis and for Epo. There's also been an ongoing effort to electronically link facilities to the networks and CMS for improved data collection.

So your mailing materials included other key design issues that would need to be considered when implementing quality incentives for this sector. The first question is which providers. And here both facilities and physicians, it's a partnership and both together work to improve beneficiaries quality. The actions of both parties affect patients quality of care. Recall that physicians caring for dialysis patients receive a monthly capitated payment. So they are seeing -- under the new revision to the fee schedule, physicians seeing dialysis patients will

be seeing the patient at least once a month.

The second question is how should provides be rewarded? Here we looked at the new ESRD demonstration project, which rewards providers both based on improvements within the facility as well as whether or not their level exceeded a national target. That, to us, seemed like a reasonable and fair approach to do that. In the demonstration, a small set-aside of payments are used. And here we think that could be roughly 1 to 3 percent of payments.

For dialysis facilities anyway, total payments from dialysis, erythropoietin and other injectable drugs averaged roughly about $2.8 million in 2001.

The next question asks how should quality be measured? Again here, we've discussed some of the measures already, dialysis adequacy, anemia status. CMS does not yet have a clinical performance measure for bone disease, but the National Kidney Foundation, like I said, has developed a clinical guideline and CMS could readily use that to develop a clinical performance measure here.

I raised the issue about the need risk adjust. And I just wanted to mention here that our June 2003

analysis of dialysis quality and providers cost also included many case-mix variables from the medical evidence form and did show that quality is related to case-mix. So that would be a very important factor in implementing quality incentives.

I guess I'd just like to also just reiterate that CMS and its contractors are well versed at developing and measuring dialysis outcomes and, in fact, they are published already on a facility level basis on the compare website. They are reported for dialysis adequacy, anemia status, and survival.

DR. REISCHAUER: But these aren't risk adjusted?

MS. RAY: The dialysis adequacy and anemia, to my knowledge are not. The survival is listed in three categories so it's as expected, more than expected, or less than expected.

So that leads us to our draft recommendation, that the Congress should establish a quality incentive payment policy for outpatient dialysis services. The spending implications of the recommendation as it's currently crafted is none. And it would maintain access to high quality care for beneficiaries.

MR. HACKBARTH: So we're talking about, you referred earlier, to 1 or 2 percent. So we would set aside 1 or 2 percent of the expected payments in the pool for distribution based on the quality indicators?

MS. RAY: Right.

MR. HACKBARTH: So it's a budget neutral proposal.

MS. RAY: Right. I think my mailing actually had 1 to 3 percent but it's 1 to 2 percent.

MR. HACKBARTH: Just one other clarification. We talk about risk adjustment. Are you saying that there's a risk adjustment method that exists on the shelf that could be applied for this purpose or not?

MS. RAY: There is sufficient data out there, I think, to risk adjust the measures, both with the medical evidence form as well as all the other Part A and Part B claims that CMS's contractors -- that would be the USRDS over at the University of Minnesota and the folks over at the University of Michigan -- who are currently doing CMS's broader bundle. They're actually looking at case-mix adjusting the broader bundle payments using case-mix measures, but there is a lot of work being done in this right now.

MR. HACKBARTH: I have Dave Durenberger, Jack, Joe and David Smith.

MR. DURENBERGER: First, I just want to compliment you on the analysis. I can't get this excited as you can about this, and I'm sure glad you can. It is really, really well done.

But it led me, particularly as you got to the key design issues, it led me to observe that the answer to your second bullet, how should providers be rewarded is with more patients. I've got my health savings account add-on. Providers should be rewarded with more patients.

And the third bullet would be how should quality be measured and reported?

I would just hope that between now and June you might add -- whether it's in the narrative or wherever it is -- some thoughts about the role of the patient, in particular, in judging quality. You well expressed the concern about cherry picking and so forth in the system and it seems to me the degree to which these patients who are going to be patients for a long, long time are well informed about not only the providers and the services they are receiving, but also about their own role. And I'm making

some assumptions because I'm not knowledgeable that if nutrition and nutrition management is a critical factor here, then the patient plays a big role. It isn't just the provider's role. The patient plays an important role.

And so from our standpoint, thinking about an ideal way to look at the role that the financing plays in quality improvement and enhancement, we ought to focus or ask somebody to focus sometime on the role of the patient in all the respects. If you think that's a good idea, I hope you would look at it.

MR. HACKBARTH: I think that's an excellent point. I don't see it as mutually exclusive. I think you can both have a financial reward for providers and use the same information to educate patients and potentially shift patient volume over time, as well. I think they're complementary, not mutually exclusive.

Jack Rowe.

DR. ROWE: I have a couple of points here. I agree this is very well done.

I think you gave some examples, Nancy, of the importance of both physicians and facilities in your comments but I think we could have a little more of that in

the text itself. I think it's really key here from my point of view, and I've had the opportunity to talk with the staff a little bit about this, that we all recognize that the physician can be incentivized to improve quality very significantly in a number of ways by paying closer attention to issues such as nutrition and hematocrit and KT/V and vascular access and all of that.

But in addition, the facility can. Because if you can imagine that if there was a significant incentive for facilities to enhance nutritional status, and if a facility was big enough, it would be incentive to hire a dietitian to be there. The patients are sitting there on the machine, and give much more advice and counsel and review of dietary habits and diet content and everything else, and do measures of the nutritional status, et cetera. And a variety of those are available beyond albumin. And so I think it's important to emphasize we have to incent both the doctors and the facilities.

With respect to that, there are some places in the document where it's ambiguous. For instance, on page 16, that's one case but there are others, where you talk about CMS as planning to incent providers. And you don't make it

clear whether they mean doctors or facilities. It sounds like facilities to me.

MS. RAY: In the new demonstration it is just facility.

DR. ROWE: But I think what I'd like to do is have us adopt an approach here where we don't just talk about providers, like on these slides, but doctors and facilities because I think we have to deal with them separately.

With respect of the quality issues, I think 1 to 2 or 1 to 3 percent doesn't sound like a lot. But then, when you start to look at these margins, it begins to look pretty significant in terms of the proportion of the margin. So I think it is a meaningful number.

MR. HACKBARTH: The other thing on that, my first reaction was that's not very much. But if it's 2 percent and, depending on your distribution formula, only 25 percent qualify there's a lot of leverage there. So you have 2 percent of the total payments going to 25 or 30 or 40 percent of the providers. They're getting a pretty significant bump.

MS. RAY: I'd don't follow your comment about 25 to 40 percent of the provider population.

DR. ROWE: He's saying only one-quarter of them qualify and if it's cost neutral you take 2 percent of the whole thing and you give it all to that quarter, then they're going to get 6 percent.

MS. RAY: I know I mentioned in my mailing materials and I don't know if you're referring to this NCQA threshold of the number of patients to develop a stable -- that's not what you're referring to?

MR. HACKBARTH: No, it's not. What I'm referring to is the design and I'm jumping way ahead so let me go back a couple of steps.

Part of implementing a program such as this is deciding how much money is in the pool and then the second part is what's the distribution formula. A couple comments on that.

One is, in keeping with our past discussions, I think what we're talking about is giving the bulk of the incentive payments to providers who have the absolute highest levels of performance on the pertinent measures but reserving a piece of the pool to reward providers who have shown significant improvement in their performance. I think that's the approach that we've talked about.

And then the next question is okay, if we're talking about the providers with the absolute highest levels of performance, where is that threshold set? Is it set so it's the top 10 percent of providers, the top 25 percent of providers? That's the issue that I was leaping ahead towards.

If you focus the incentive payments on 25 or 30 percent of the providers with the absolute best performance, then the leverage becomes pretty significant.

DR. ROWE: I agree with that and there are a couple of different ways you could do it. I would also suggest that with respect to the quality measurement, with respect to both the physicians and the facilities, you could consider a floor of acceptable quality that we could migrate northward over time, as well as a level of quality or a change in quality that would trigger a payment. And if you did that the floor would be what you would have to reach in order to be an accredited Medicare nephrologist or facility. And if you didn't meet it, you didn't meet the conditions of participation.

Now there are access issues, et cetera, here. But if we're serious about paying for performance what you could

say is this is the standard of care that we believe Medicare beneficiaries deserve. We finally have found an area on medicine that we can measure quality, we think, reliably. And if you don't meet this, then you don't get to have Medicare beneficiaries, either as a doctor or a facility.

So you can use quality two ways. It's not just moving the money around in a cost-neutral way. It's also, perhaps, influencing volume. Because if there are two facilities in the town -- this gets to David's point -- or two nephrologists in the town, and one isn't meeting the minimum quality standards, then the other nephrologist is getting those cases. He doesn't have to get paid any more per case.

Another point on this is risk adjustment. I think that the assumption in your comments was that there are some ways to risk adjust this, that it would be important to risk adjust it, and I agree with that. But the assumption, I think in what I read and heard, is that it would be the entire population.

I think one of the problems with this population is that if you've seen one dialysis patient, you've seen one dialysis patient. They're very different. There's a subset

who are diabetic, that may be 40 percent. Then there are patients waiting for transplantation. Then there are patients who are dying of some other disease and they're going to gradually do worse and worse, independent of what the quality of the doctor or the facility is. Their measures are going to go down because, in fact, they have a fatal disease. We shouldn't be penalizing the facility or the doctor because somebody with disseminated cancer is losing their functional status. So we have to be careful about it.

And I would think that one way to do it is to go with it and say okay, we're not necessarily going to use these measures for incentive payments on the entire patient population. We're going to take a subset, as we start, of the patient population. We'll take all of the diabetics and the polycystic kidney disease patients or whatever, and we'll use those, risk adjust those within those categories. It might be half the population to start, walk before we run, and not wind up penalizing facilities because some of the patients -- because they're willing to take patients who, in fact, are dying or who are very impaired or whatever. Because we don't want people cherry picking and

being disadvantaged because they didn't take a patient.

It's mentioned here but I'm just thinking of a way of getting around it, particularly for a small facility that's got 15 stations or something, or a nephrologist with a small population of patients.

So these are just a couple random thoughts about how you might go ahead with this. I think it's very, very interesting. And I would push you further along on the bone disease access ideas, as well, and see if we can find five, not two, measures. Thank you.

DR. NEWHOUSE: I had a couple suggestions, one for research that might change this slide.

Table 4 in our briefing materials has some notable gains in quality of care. The percentage receiving inadequate treatment goes down by half over four years, from 22 to 11, and percentage with low anemia goes down by more than half from 57 to 24.

My suggestion is that you might think about whether you can do any analysis that would look at whether that has had any effect on other Medicare costs for this population. Because if the quality incentives are effective -- and if they're not effective why are we doing it -- and

there are effects in other areas, the fact that you're not getting inadequate dialysis means you don't have to be hospitalized at some point. Then the spending implications are actually that this is cost saving.

And it would be nice if we could have some documentation of that. I would think, in principle, that analysis could be done.

The second point I wanted to make was that there was a Ph.D. dissertation done a few years ago on quality of care in the New York cardiac surgeon system that looked at variability over time. In fact, there's quite a bit of variability, and a lot of the variation is just kind of random noise because of inadequate risk adjustment, which suggests -- the student developed some statistical methods for smoothing this over several years.

Which suggests if we go forward with this and probably also beyond the ESRD setting, that if we're going to reward performance, we would do some kind of multi-year average performance, so that you didn't get bounced in or out of your bonus or penalty by some random draw from the patient mix.

MR. SMITH: Thanks, Glenn.

Joe joins Jack and David in raising some of the questions that are in my mind, so I'll be brief.

But it does seem to me that the design issues here are tricky. I have no idea whether or not 1 percent or 2 percent is powerful enough, and whether or not across settings whether or not the same percentages would hold. I think we need to think more carefully about that. But it obviously depends a lot on how the 2 percent is distributed. If you distribute it to 80 percent of the providers, it's not as powerful if you distribute it to 40.

But that connects with another design issue, which is what you hope with a quality payment incentive is not only the folks who win the prize this year improve, but that everybody improves. That this has got a pull effect on the system as a whole. We need to be careful that we don't concentrate so much on the leverage issue that we neglect the pull issue.

Which connects with Jack's question about whether or not there's a facility death penalty. It's an important one, but it has very important access issues and probably access issues not simply quantitatively but distributionally as well. We ought to think about how to link that question.

I think Jack's right to raise it, that it becomes a condition of participation to meet a threshold. But maybe in a more subtle way to link it with the issues that Dave raises about can we use this to drive patients to high quality providers, perhaps even thinking about financial incentives to patients, not simply access to high quality information about quality differences.

These are tricky questions that are going to come up again and again over the next two days. They're going to be very important in January. I think we ought to step back and ask ourselves is there a systematic way to try to think about this? And most importantly, how do we make sure that even though only Nick gets the reward this year, that my incentive to improve is as powerful?

That's how we make the system better, not by figuring out how to distribute 1 or 2 percent around a very small number of already, in most cases, already high quality providers.

MR. HACKBARTH: Those are excellent points.

I think isn't part of the answer a tool for addressing the latter point is by reserving a piece of the incentive pool for improvement, as opposed to just using it

all to reward absolute high levels of high performance?

MR. SMITH: I think that's right. Again, the distribution of whatever the incentive pool is among high rates of improvement above whatever the appropriate minimum threshold is, how that compares to how you distribute this to already high quality providers.

To some extent, as we think about the broad beneficiary population, we ought not to be interested in spending as much money to reward high quality as we would to reward high levels of improvement.

On the other hand, who knows what that induces at the high quality providers if they are somehow -- they can't get an increased piece of the action until their performance declines so that it can turn around and improve. That would be obviously a perverse outcome. So this is trickier, I think, then we're yet up to, but critical stuff.

DR. STOWERS: I won't belabor what David said, but I was going to talk about the same thing. I have a little bit of a problem with this high amount of set-aside for the few that reach a real high standard and de-incentivizing the masses of a beneficiaries that we're really trying to get the standard raised, rather than setting some kind of a

reasonable standard that a lot more could meet and be incentivized to reach.

The other thing, I think, we've talked about for a long time is whether this set-aside ought to come out of existing payments or whether it ought to come out of updates along the way. There's kind of a de-incentivization along the way if we talk about taking out of their existing payments and then try to fight to get that back. I think we maybe want to be clear that when we talk about taking set-aside money that it's not coming out of what they're making now.

MR. HACKBARTH: The dollars are fungible. Mathematically I think it works out the same but there may be an important packaging question.

DR. STOWERS: But it's a packaging question because you hear on the street, so to speak, that they're going to take it away from me and I have to fight back for it, so I don't want in this quality thing.

DR. ROWE: Ray, as I recall, we have like 13 years without an update. So if we promise them that we're going to give it to them in the updates, that might not be too incenting, because they're not going to believe there is an

update.

DR. STOWERS: I hear you. But instead of an updated we now have this quality money. I'm saying instead of. We now have quality money out there that you could earn.

MS. DePARLE: Is there a recommendation that there be an annual update? I know we're making a recommendation for an update this year, but are we recommending to Congress anything about putting that into law?

DR. ROWE: It's in the bill, isn't it? The Medicare bill.

MS. DePARLE: I don't think so. It's not in the bill. They gave them an update for one year.

MS. RAY: Right. The bill gives them 1.6 percent in 2005. We can, of course, discuss if the Commission wants to go down that road about whether or not --

MS. DePARLE: I think it's the only provider that doesn't have some provision in law, is that right?

MS. RAY: My impression is all the other providers do have that provision in law, yes. I mean hospitals and...

MR. HACKBARTH: Implicit in what we do, and we do review the rates each year, is that within our framework

they do have an annual update analysis. But you're right that something the industry has sought is a formal legislative recognition of that.

MS. DePARLE: That wasn't actually my point. It's just Jack reminded me about the 13 years.

I'm excited about the opportunity here to do something to improve quality, but I guess I just want to agree with David that I think it's tricky and so I have some both substantive and practical packaging, I think was the word you used, policy concerns about the way that we go about this and the design of it.

Given what we just saw about the trends and the margins in the industry, I don't feel comfortable saying that what we would do on a quality incentive payment policy should be budgeted neutral. I also think the recent history of these ideas, which is very recent since the one I'm aware of is what's in the current Medicare bill, is to make it on top of whatever the provider is getting.

In an ideal world what Jack and Joe have talked about, where you would have a condition of participation that everyone has to meet that's much higher than people are meeting now. And then you go on beyond that, that's how

we'd all choose to operate. But I just don't think that's realistic.

And so I think if we want to move forward here, I would not vote to do this budget neutral at this point.

DR. NEWHOUSE: I just wanted to comment quickly on the issue that both David and Ray raised by doing it on an absolute level of quality versus a change in quality or an improvement.

The reason I would de-emphasize, though not zero the improvement side, which I think it sounds like you would emphasize, is a portion of what you were alluding to were the high performer degrading their performance to improve. But in general, anybody looking at this would say what's going to happen downstream in future years?

Depending on how the payment formula goes for how much payment there is for how much improvement, I may choose to withhold some improvement I could make now to more improvement next year and get my payment next year if I'm looking at something that if I do the best I can this year I get something more this year but then I get nothing more than future.

In general, I think there's serious issues with

how the improvement thing plays out over time, which is why I would put more of the money on absolute performance, though I don't have really well-formed notions of whether absolute means the top 10 percent or the top 70 percent.

MR. SMITH: I think this is exactly the way, Joe, that the question of how do we distribute a quality pot interacts with the question Jack raises about an absolute threshold as a condition of participation. It seems to me that if we could link those two notions, that we've got a part of money somehow divvied up between high performers and improvement, but we've got a threshold which assures us of a minimal level of quality and then are prepared to reward improvement more than absolute performance above that level, my guess -- but it's why I think these are tricky question and not easy ones -- my guess is we'd have a broader impact on a larger beneficiary population, which ought to be one of our objectives.

DR. NEWHOUSE: That's correct.

DR. ROWE: My concern with your thought, Joe, and it's kind of an interesting question about absolute versus change over time, has to do with the clinical reality.

I think that you can have an absolute measure if

it's a process measure. Did the patient did Epo? Did the patient get an albumin measured? Did the patient have a dietary consultation? Did the patient do this? Did you do that?

But if you have an outcome measure, a clinical outcome measure, what is the functional status of the patient? What's their weight? What's their muscle mass? What's their blah, blah, blah? It takes a long time to build up bones for people who have renal disease-related osteomalacia. It takes a long time to get people to understand the dietary restrictions and to be compliant with the diet and get back in shape, et cetera, et cetera.

What you want to do is if somebody is going from a relatively low level and is improving and getting toward your standard but not yet there, you want to certainly reward them.

So I think if we had process measures, I'm with you. If we have clinical outcome measures, I'd like to see some consideration for improvement. We can go around and around on this, but I would like to make that distinction.

MR. HACKBARTH: The other thought that raises in my mind, if you're talking about outcome measures and

there's imprecision, as there inevitably is, in your risk adjustment, having an improvement payment is perhaps a bit of a hedge against imprecision in your risk adjustment.

If you've got a facility that's consistently attracting caring for patients that are more complicated and higher risk, beyond which you fully account for in your risk adjustment, they may look poor on your absolute values, but if they are improving compared to themselves over time then they would be rewarded.

DR. NEWHOUSE: The improvement may just be because the risk adjustment was incomplete so I got better patients next year. You may be just rewarding noise in the improvement.

MR. HACKBARTH: Yes, and that's an issues with risk adjustment across the board in linking payment.

DR. NEWHOUSE: It's more of an issue in change than in levels.

MR. HACKBARTH: Lots of things to discuss.

Thank you, Nancy. We need to move on now to M+C. Very thought provoking.

MR. DURENBERGER: Scott, before you begin, would you just clarify for me, when you use the phrases in the

beginning, private plans and delivery systems provide -- I'm just unclear exactly how that reads. Just so I don't have to ask it later on. You talk about doctors, hospitals, blah, blah, blah, all that sort of thing.

DR. HARRISON: You mean what the delivery system is?

MR. DURENBERGER: What are we talking about when we say --

MR. HACKBARTH: Where are you looking Dave, so we can all get on the same page?

MR. DURENBERGER: In just the basic language. He uses the language private plans provide delivery systems and I just need to understand what it is. It's probably so obvious...

DR. HARRISON: That would include networks, care coordination, whatever techniques they're using to have care delivered that might be different than the fee-for-service.

MedPAC has a long history of supporting private plans in the Medicare program. The Commission strongly believes that beneficiaries should be given the choice of delivery systems that private plans can provide. Private plan, through financial incentives, care coordination, and

other management techniques, have the potential to improve the efficiency and quality of health care services delivered to Medicare beneficiaries.

The current incarnation of privatize plans is the Medicare+Choice program. The Medicare+Choice program has provided the majority of Medicare beneficiaries a choice of delivery systems and MedPAC has supported that choice and pushed for the choice to be financially neutral to the Medicare fee-for-service program.

Congress has just passed legislation establishing a new Medicare Advantage program, however much of that program will be based on M+C plans. M+C plans will become known as Medicare Advantage and many of the same issues we have been addressing will continue to need addressing.

The reform bill has given MedPAC several mandated studies involving broad issues surrounding Medicare Advantage plans, including a study due in 18 months that will give us the opportunity to examine financial neutrality and payment area issues.

For the short run, including our work today, we are focusing on issues that are important for the current program as it transitions to the new program. And these

issues, however, will also be important for the long run.

Dan and I will present three draft recommendations today. The first two arise from the new risk adjustment system that will be implemented in January. MedPAC has stated many times that risk adjustment is crucial if we are to pay private risk bearing plans properly. This would include not only M+C plans but also drug plans and Medicare Advantage plans.

Risk adjustment can be used to help create financially neutral choices. CMS has made a choice in implementing the new risk adjustment system that has the effect of moving away from financial neutrality. And the first draft recommendation would have CMS reverse its decision.

The new risk adjustment system also presents an opportunity to expand plan choice to ESRD beneficiaries. And the second draft recommendation would take advantage of that opportunity.

The final draft recommendation reflects an extension of the Commission's analysis of using payment incentives to improve the quality of plan services. I will present that draft recommendation after Dan has finished

presenting the first two.

DR. ZABINSKI: An important change facing plans in 2004 is that CMS will begin using a new system for risk adjusting their payments. A little bit of background on this thing is that the Agency has named the new risk adjuster the CMS-HCC. And this model measures an enrollee's risk, that is their expected costliness, using the demographics and conditions diagnosed during inpatient, outpatient, and physician encounters in the previous year. This model should be an improvement over the current risk adjuster, which uses only diagnosis from inpatient stays to evaluate enrollee's risks.

Probably the most important attribute of this new risk adjuster is it has the potential to substantially affect payments.

Today I'm going to focus on two key developments regarding the new risk adjustment system. The first key development is that in 2004 CMS will make proportional increases to all payments adjusted by the CMS-HCC. The purpose is to offset reduced payments that would otherwise occur under the CMS-HCC to make them budget neutral with a demographic adjuster that CMS currently uses in setting M+C

payments.

Some argue that this policy is necessary to help stabilize Medicare+Choice and prevent plan withdrawals.

A second key development regarding the new risk adjustment system is that CMS has created a version of the CMS-HCC designed specifically to adjust payments for ESRD beneficiaries. These beneficiaries are currently barred from enrolling in Medicare+Choice, in part because the method currently used to risk adjust payments performed quite poorly. But the new risk adjuster should do much better.

Over our next four slides, we present issues related to these two developments I just discussed and two related draft recommendations. First, I'll discuss concerns over CMS's decision to proportionally increase risk adjusted payments in 2004. Previously, the Commission has recommended that M+C payments should be risk adjusted and that payments should be financially neutral between the Medicare+Choice and traditional Medicare sectors.

And just to refresh your memory, financial neutrality means that on average payments should be equal in Medicare+Choice and traditional Medicare after accounting

for differences in risk.

It's the job of risk adjustment to account for those differences in risk and put the M+C and fee-for-service sectors on a level playing field in terms of risk differences. But CMS's decision to proportionally increase risk adjustment payments in 2004 will have the adverse effect of moving us away from the concept of a level playing field and financial neutrality.

Another concern over CMS's decision to proportionally increase risk adjusted payments is that CMS may have overestimated how much the CMS-HCC will actually reduce payments. This is because the data that CMS used to estimate the impact of the CMS-HCC on payments came from a time when payments depended little on how providers in Medicare+Choice code enrollee's conditions. Consequently, providers may have under-reported conditions, making enrollees look healthier than they actually are. But providers will likely be more diligent when coding conditions --

MS. ROSENBLATT: Dan can I ask a clarifying question on that? That third billet, CMS may have overestimated, if I were to ask somebody at CMS why they did

that, would this be their answer or are you guessing that this is their answer?

DR. HARRISON: Are you asking why they overestimated?

MS. ROSENBLATT: Why they're making the adjustment, the 4.9 percent? If I were to go to somebody at CMS and say why are you making the 4.9 percent adjustment, what would their answer be?

DR. ZABINSKI: I would say that it's to help stabilize the program. That's in their notice last March and they had the 45-day notice and then the final notice last spring. And that was in the notice, that the purpose was to stabilize the program.

MR. HACKBARTH: That's what I've heard personally from people in the administration as to why they think this is important.

DR. ROWE: [off microphone.] Because of this reason that the doctors or the hospitals in Medicare+Choice --

DR. REISCHAUER: No, it's that if they took the 4.9 percent out of the system plans would drop out.

DR. ROWE: Can I ask you, just to clarify, what

exactly -- on page five you say they want to put 4.9 percent in to make it budget neutral. Right? You said in 2004 CMS will increase the risk adjusted payments by -- and then the actual number is 4.9 percent -- to make them budget neutral with the demographic adjuster, right? That's what it says.

Now this one says increasing the risk adjusted payment moves us away from financial neutrality because you think it's too much. You think it's too much or you think that adjustment shouldn't be made at all because the adjustment theoretically moves us away -- I'm trying to figure out whether we're against any adjustment because it's inconsistent with the principle, or you think the numbers too big?

MR. HACKBARTH: They're two different benchmarks. One, when the administration, when CMS refers to budget neutrality, they're comparing the payments under the new system to what would have been spent under the old demographic system. So it's budget neutral relative to that. Plans get paid the same amount as they would have before --

DR. ROWE: [off microphone.] That's budget neutral longitudinally.

MR. HACKBARTH: The other reference point is are we paying the same amount that traditional fee-for-service Medicare would have paid for the same patients? That's the financial neutrality that MedPAC has focused on in the past. So there are two different benchmarks.

So a system that is budget neutral relative to the demographic adjustment is not neutral relative to what fee-for-service Medicare would have paid. What we are finding is based on these new risk adjustment measures that the enrolled population in private plans is healthier than in fee-for-service Medicare and their payment should be falling as a result of improved risk adjustment.

MS. ROSENBLATT: Can I ask one more clarifying question? Was there any reason why -- we went from demographic to PIP -- whatever it was called -- to the new thing. Why do they go budget neutral to demographic instead of the PIP one?

DR. ZABINSKI: I don't know.

DR. HARRISON: Actually, in '03, this year, they actually went budget neutral to demographic using the PIP-DCG. So there's a little bit of money this year that was given back, like .6 percent, something like that, to get

from the current 90/10 blend of PIP-DCG back down to the demographic. So they've done it two years, '03 and '04.

DR. MILLER: Just the conceptual response to the question is that they were trying to maintain the dollars that the plans were currently getting? Is that a fair response? Under the old risk adjustment system. the new risk adjustment system would have pulled their --

MS. ROSENBLATT: That's what I'm asking. It sounds like it didn't go to the 90/10, it went back to demographic. Or am I not understanding it?

DR. HARRISON: That's right, it's going back to the demographic, which I guess we sort of consider to be the old system.

MS. ROSENBLATT: It's as though anything beyond demographic never happened.

DR. HARRISON: Yes.

DR. MILLER: This is more of a sidebar. The other reason that people will give for this is that there are differences of opinion about how the legislation is interpreted. When the law was written, there are some who argue that this was the intent of the law and some who argue that this was not the intent of the law. So you have that

overlay just to make it a little more confusing.

MR. HACKBARTH: Of course, what we want to do is bypass what is the correct legal interpretation of the existing law and not get involved in that at all but simply discuss what we think the appropriate policy should be for the program.

DR. ROWE: [off microphone.] I guess at this point we're at the point where we're looking at the recommendation, so I'll hold my question until then. But I want to ask it before we get to dialysis.

MR. HACKBARTH: So why don't you proceed.

DR. ZABINSKI: Now because of these issues regarding CMS's policy to proportionally increase the risk adjusted payments, we have developed this draft recommendation, that CMS should not continue to adjust payments under the CMS-HCC to make them budget neutral with the current demographic adjuster. This demographic would have no impact on program spending nor would it have an effect on beneficiaries or providers. And this is because there has not been action to increase risk adjusted payments in any way in 2005, which is the time when this recommendation would first apply.

DR. ROWE: What's not clear to me, and maybe -- I was at risk for understanding it a minute ago in the conversation but I think I need more help.

Let's get to the neutrality question of M+C versus traditional, which is the second version of neutrality.

MR. HACKBARTH: [off microphone.] Right, and the one that we focus on.

DR. ROWE: Congress or somebody raised the payments in the so-called floor counties, right? That was sort of done. And that was done for whatever policy reason, access, choice, whatever it was.

When we're now comparing the payments in M+C versus traditional for the relative morbidity or risk associated with the population, are we taking out that extra payment that was added to the floor counties, so we're comparing apples to apples? Or are we including those extra dollars that were put in those floor counties because that was a separate policy issue that was done for a separate reason? So it seems to me we should take that out and then see how much are the M+C plans getting paid for the same patient? Is that clear?

MR. HACKBARTH: Yes, it is clear.

Just to clarify that record, we opposed the floor payments, as well, because they violated the neutrality principle and we thought they would be ineffectual at any rate. Now there's a second question of neutrality.

DR. ROWE: [off microphone.] But isn't that influencing our calculation?

MR. HACKBARTH: The staff have consistently given us two numbers. One which is the overpayment that results from the floors and that stuff, and then a second that is the additional overpayment attributable to the approach to phasing in risk adjustment, the budget neutrality provision of risk adjustment. So why don't you tell us again what those two distinct numbers are?

DR. ZABINSKI: The overpayment from the floors, et cetera, as Scott has estimated, is that the average payment rate is about 3 percent higher than what the average fee-for-service beneficiary costs.

DR. ROWE: If you take that out, then what is it?

DR. ZABINSKI: Then it's zero. Well, it would reduce the base payment rates by 3 percent, on average, if you take that out. Basically, if you set all base payment rates equal to focal fee-for-service spending, then the

average base payment rate would go down by 3 percent.

DR. ROWE: So what you're saying then is we're currently paying plans 103 percent, but if we correct for whatever the reason was, floor payment thing, we're actually paying out 100 percent of fee-for-service?

DR. ZABINSKI: Right.

DR. ROWE: Because that's an important --

DR. HARRISON: That's for a demographically similar population.

MR. HACKBARTH: That's assuming there aren't any selection issues. The increment that would be attributable to using the current budget neutrality approach, if it's done through the full phase-in, is an additional increment of 16 percent.

DR. HARRISON: Let me talk about that number for just a second. The way that number was arrived at, CMS did a simulation. They said okay, we're going to pay you under the demographic system. You get X dollars. We're going to take your same patients that we have the data for. We're going to run them through the new system and find out what we're going to pay you. And it turns out you'd get 16.3 percent less. That's where that number came from. That

includes the floors, right. That includes what would happen changing this one risk adjuster. So that's where that number comes from.

It may not always be appropriate to add or multiply that with the other differences because we do have some mathematical issues, but that's generally where we are.

MS. THOMAS: I think it's also important to point out that that number could change based on what plans actually enroll and how thoroughly they code diagnoses. So it's an order of magnitude number, -- not an absolute number that we should be focusing on.

MS. ROSENBLATT: If I could just, I have a lot of problems with that number because I don't understand what you mean by simulation. It's a much different number. You know, I think we've all been thinking that the selection impact, ever since the Rand study was done, was sort of the range of 5 to 7 percent. And now all of a sudden we're looking at a number like 16 percent.

Whenever something like that jumps in my world, there's usually a data problem.

So I am very concerned, when I read the stuff for this meeting, I was really concerned about how often we used

that 60 percent. Because I'm worried that it's not even an appropriate order of magnitude, given that we've all been thinking about 5 to 7 percent for years now.

DR. HARRISON: We think that's right. We think the number will probably will come down. But one of the dangers of the policy is that that number is locked in as an add-on.

MR. SMITH: The 4.9.

DR. HARRISON: Right.

DR. MILLER: Just to be clear, first of all we agree with you and we're trying to not repeat that number as much. And you're right about the materials, and we have had a lot of discussions ongoing while we're doing this work. Your point is well taken. That's a CMS number. We think that CMS may estimate it.

However, if the policy were to be rolled forward, even if your mix of patients change, there still would have been an estimated 16 percent add-on to the payment because that percentage was basically built in.

The other point I would make is 6 percent, 16 percent, forget the number. It's the principle that I think we're really trying to focus on here.

DR. ROWE: Let me see if I can --

MS. RAPHAEL: I just want to see if I understand the recommendation, because I'm not sure that I do. And I'm going to restate it and tell me if I have this right.

We're saying CMS should adjust payments under this new system, the CMS-HCC system. That's the first thing. We're in favor of that. What we're not in favor of is adjusting payments under that system to make them budget neutral with the current system, which is based on demographic adjuster. Is that it?

DR. ZABINSKI: That's it.

DR. ROWE: Just to get the language straight, on page three, let me just read the first statement we have, because maybe not everybody is quite as into this is you guys, and then we'll read this statement. Page three.

Three draft recommendations. Number one, risk adjustment should support principle of financial neutrality. That's what it says. Recommendation: CMS should not continue to adjust payments -- dah, dah, dah -- to make them budget neutral with the current demographic adjuster.

I would suggest that unless you're really a cognoscenti, it does appear that those two statements are

conflicting.

DR. MILLER: We will work on the words. That's fair.

MR. HACKBARTH: [off microphone.] This is helpful. The wording is delicate and we need to do a better job.

DR. ROWE: So what you're saying is you're in favor of budget neutrality, but not this budget neutrality.

DR. ZABINSKI: No, we're in favor of financial neutrality but not budget neutrality.

DR. ROWE: Are we talking about amortization or capital expense? What do you mean financial but not budget?

MR. HACKBARTH: Maybe a way to express it, maybe, is that what we're opposed to is holding plans harmless against the effect of the new risk adjustment. We think the new risk adjustment is as a good thing to do and we ought to pay according to its results as according to base payments based on the old demographic system.

DR. NEWHOUSE: [off microphone.] Maybe we should say what we should do.

DR. REISCHAUER: But we're only holding plans in the aggregate harmless when what we want to do is if the

application of risk adjustment leads to an aggregate savings, that should rebound to the benefit of the program and not to the Medicare Advantage subset.

DR. ROWE: So are we talking about having the same amount of money for the plans and redistributing them around the plans by virtue of some measure of the risk? Or are we talking about reducing the amount of money we would prefer, reduce the amount of money in the plans to make it more relevant to what's going on on the other side?

DR. NEWHOUSE: We're in favor of two.

DR. REISCHAUER: Number one is the policy.

DR. ROWE: And number one is the policy, right.

So we should change this language to say that?

DR. MILLER: We will redraft it.

DR. ROWE: And tell me about the difference between revenue and budget?

DR. ZABINSKI: We've made this financial neutrality recommendation a few years ago. Basically you want to pay the same for a beneficiary whether they're in fee-for-service or Medicare+Choice. In order to do that you need to risk adjust them properly. That's financial neutrality.

What the budget neutrality adjustment does is you initially risk adjust it and then you add an additional payment on top of it to make it budget neutral. So you're no longer going to be paying an equal amount in fee-for-service as in Medicare+Choice. You're going to be paying more in Medicare+Choice for that person.

DR. ROWE: [off microphone.] So you're mitigating the effect of the risk adjustment in this case because it turns out they're less risky. If the people in M+C were more risky, then they'd be getting more.

MR. SMITH: [off microphone.] Think of it as payment neutrality rather than budget neutrality.

DR. ROWE: [off microphone.] Right, but I think not everybody is going to understand the difference.

DR. ZABINSKI: I think this budget neutrality term has been unfortunate, but that's been the one that's been sort of used by the CMS.

MR. SMITH: Let me come back to Alice's question for a minute.

If the 16.3 is wrong, and we say in the text that it is wrong. We don't know what the right number is, but we know that it's wrong. But the 4.9 is law. So the closer

the 16.3, Alice, gets to five or six or seven, the more distorting the 4.9 will be.

Of right number is say 7.3 percent instead of 16.3 percent. we are going to compensate the plans at a level that assumes that the 16.3 percent is the right number to reflect the healthier population in the plans. So the closer the number comes to your expectation, the more distorting the 4.9 percent gets.

MR. HACKBARTH: That's part of the problem, is locking into this number as the right number for the phase-in.

MS. ROSENBLATT: My concern is that somebody is going to read the way this is written now -- and I'm glad to hear it's going to change -- and say oh my god, plans are being overpaid by the 16 plus the three. There will be an assumption that plans are being overpaid by 19 percent. And I just look at reality that says a lot of plans have been withdrawing. If they were being overpaid by 19 percent, trust me, nobody would have withdrawn.

MR. HACKBARTH: That raises another issue that is still another source of confusion. Again, our consistent benchmark about appropriate payment is what would have been

spent for the same patients under traditional fee-for-service. That is our guiding star in all of our recommendations in this area since I've been on the Commission.

That does not meet that the payments are adequate to cover the plans' costs or the plans are reaping large profits. That's a completely different issue that has to do with the cost structure of plans. In fact, having been in this world and worked for a plan trying to do this, I know what a disadvantage it is to have higher administrative costs, the marketing costs, and in the case of for-profit plans taxes and the like. So you're behind before you even start in this game.

So the plans' cost structure is a completely separate discussion that we've not taken up. We're talking talk about how payments compare to fee-for-service Medicare.

MS. ROSENBLATT: I agree with that and that was going to be the second part of my comment, Glenn, because there's an example in the paper that uses $100 and $84. And I think that example clouds that issue that you just bought up. I think it really makes it looks like the $100 is an adequate number and it's not.

MR. HACKBARTH: I think that's a good suggestion. In fact, it's something that Jack and I talked about on the phone. As we write this material, we need to draw out this distinction and address the issue of paying costs, not empirically try to measure it but just say that's a conceptually different issue and plans may have higher costs in some respects.

DR. ROWE: I had three things that I wanted to try to put into the conversation or the discussion part of the paper anyway, that I think address this and give people a fuller feeling for it. One of them is these inherent costs associated -- it's just a different design. That's fine. This is a voluntary program. Plans don't want to participant, they don't have to, as we've seen.

Secondly, is the assumption that the benefit package is the same. It's kind of an assumption, you're either getting this benefit in M+C versus you're getting it in traditional. And the fact is that there are benefits in M+C that are not in traditional, preventive benefits, other kinds of disease management programs, et cetera. So we should at least recognize that.

The third is the payment from the point of view of

the beneficiary because we're always comparing M+C to traditional but, in fact, in the real world it's M+C versus traditional plus Medigap because the beneficiary is paying the Medigap premium. Now a lot of those Medigap programs may disappear overnight with the pharmacy benefit, the expensive ones with the pharmacy benefit are probably not going to be --

DR. NEWHOUSE: [off microphone.] Only 8 percent of them have a drug benefit.

DR. ROWE: So I think that if you add those three things in the benefit may not be exactly the same because it's saying it's the same cost for the Medicare program kind of assumes that you're buying the same product at the same cost in these two pathways. And the plans would say well, we're not really giving the same product. We're giving a different product.

So if we throw that in, I think it enriches wherever we come out in the recommendation. It at least gives it a more fulsome discussion than that example, which I think doesn't do that.

DR. REISCHAUER: But the payment that the government is making is for a similar package of benefits.

It's true that Medicare+Choice plans have a fuller package of benefits, and that's fine and that's good, but with respect to the calculations that Scott's doing, it's not relevant.

MR. SMITH: Scot, let me just check my arithmetic for a moment.

Given the MedPAC financial neutrality principle and the implications of the new legislation, is it right to say that in a floor county payments subsequent to the implementation of the legislation would be 7.9 percent higher than the financial neutrality principle would dictate? Can you add the three and the 4.9 together?

DR. HARRISON: Not exactly.

MR. HACKBARTH: Arithmetic in public is like making sausage in public, it's not a good thing.

DR. HARRISON: We've tried to do that because people keeping asking us to do that and I think we should stop because you really need to rebase things. These things are all based off of relative weights and everything. And when you throw different mixes of people from different counties in, things get very messy. The actuaries have to look at this stuff and when they redo things they need to

think about the stuff, but it's not as simple as just adding them.

MR. HACKBARTH: We need to quickly get to a conclusion here. Have we fully discussed recommendation one? I think so. Let's move on to recommendation two.

DR. ZABINSKI: Next I'd like to return to an issue I mentioned earlier, that ESRD beneficiaries currently are barred from enrolling in Medicare+Choice. The staff have identified three factors that support the notion of changing that policy and allowing ESRD beneficiaries full opportunity to enroll in private plans.

First, the new risk adjuster will pay plans more accurately for ESRD beneficiaries. Second, results from a demonstration program indicate that ESRD beneficiaries receive equal or better treatment in manage care. And finally, equity in Medicare+Choice requires that all beneficiaries should have full access to managed care settings.

That leads to this recommendation, that the Congress should allow beneficiaries with end-stage renal disease to enroll in private plans. This draft recommendation would have no spending impacts, but it might

have a positive impact on ESRD beneficiaries who may get better coordinated care in managed care settings. Also, there would be do impact on providers except that dialysis providers would have to negotiate rates with private plans, rather than simply accepting Medicare payment rates.

MR. HACKBARTH: Comments or questions?

DR. NEWHOUSE: I'm in favor of this recommendation but I'm wondering if a skeptic might say if we observed the same selection we did in M+C, wouldn't this raise what the government was paying downstream if rates got based on fee-for-service? I'm going to the spending implications again.

DR. HARRISON: But this risk adjuster that we're using a specifically designed for ESRD beneficiaries with dialysis. They actually put them in a separate pool and estimated the model.

DR. NEWHOUSE: As I say, I'm fine with the recommendation but I think you have to then bring out that you're banking on risk adjustment to keep the spending implications at none. on.

DR. ZABINSKI: I want to fully understood understand what you're saying. Are you saying that even if we have this full risk adjuster, it might not do a perfect

job?

MR. HACKBARTH: Within this class of patients there might be selection?

DR. NEWHOUSE: I'm not sure anybody else thinks HCC is the perfect risk adjuster and I would guess that you don't think the ESRD adjuster is the perfect risk adjuster.

MR. HACKBARTH: So within this class of patients with ESRD, there may be selection with the healthier ones --

DR. NEWHOUSE: It's awfully strong to say there won't be.

MR. HACKBARTH: But I'm just trying to understand your point. And to the extent that there's selection within this category, there could be an increase --

DR. NEWHOUSE: We've got the composite rate where it is, but then what this would do, when we look at those payment-to-cost ratios that we looked at in the earlier section downstream, they would be headed down if there is selection against the traditional program and there would be pressure to raise that rate. That's the only point I'm...

DR. HARRISON: Joe, are you suggesting that we want to add something about it needs to be rebased now and then? Would that help?

DR. NEWHOUSE: I haven't thought that far ahead but maybe I would just add at this point that it's important that risk adjustment be implemented as part of this.

MR. HACKBARTH: Yes, acknowledge that in the accompanying text.

DR. REISCHAUER: Under undercurrent law, ESRD patients aren't allowed to sign up once they've been diagnosed. My understanding is if they develop symptoms while they're enrolled in a Medicare+Choice plans they can stay in a Medicare+Choice plans.

DR. ZABINSKI: Right.

DR. REISCHAUER: Which means that suddenly we'll be paying them, under this system, more. So by definition -- no?

DR. HARRISON: They're currently paid a state-wide average for ESRD beneficiaries.

DR. REISCHAUER: So we already adjust it?

DR. HARRISON: We already do pay for ESRD beneficiaries in plans but it's a state-wide rate, one state-wide rate.

DR. ZABINSKI: And it's not risk adjusted in any way.

DR. REISCHAUER: It's not a lot of people, I know that. And probably many of them switch out, if they were rolled. But I think we should mention in the chapter anyway what the current situation is.

The second thing is, not to tie this with the previous discussion we had, but we also, if we're going to go into a long discussion of paying for quality for dialysis patients, we might suggest that this would also apply to these plans.

DR. NEWHOUSE: That's our recommendation three.

MR. HACKBARTH: No, he's talking about plans that provide or take responsibly for dialysis care.

DR. NEWHOUSE: [off microphone.] That's sort of a subset.

DR. REISCHAUER: Right.

DR. ROWE: [off microphone.] As long as the things that you're evaluating them on are things under their control.

DR. REISCHAUER: Same deal as the fee-for-service.

DR. NELSON: Do I understand right then, the end-stage renal disease patients enrolled in private plans would take with them the composite rate, the same reimbursement

formula as they currently take to a dialysis unit? No?

DR. ZABINSKI: No.

DR. NELSON: I understand the risk adjustment. What accommodates the additional facility costs and all that kind of stuff that goes with an end-stage patient?

MR. HACKBARTH: It's a capitated rate.

DR. NELSON: And would be set by risk adjustment to take care of the facilities --

MR. HACKBARTH: It reflects the underlying Medicare payment structure and says Medicare costs like this for these patients with this category. And so there's an added -- as we've measured it -- an added increment of costs associated with this payment category. So then you take the base private plan rates, whatever they are, whatever they were calculated, and say you get a bump up of this amount for dialysis patients.

DR. NELSON: Thank you.

MR. HACKBARTH: Next recommendation?

DR. HARRISON: In our June report, the Commission supported tying financial incentives to quality for providers and plans. In that report we developed criteria for successful implementation of a financial incentive

program. As we noted back in that June chapter, Medicare+Choice plans meet those criteria and this is really what Nancy had up.

Evidence-based measures are available. M+C plans already collect data that can be used to assess quality and not cause any added burden to the plans. Plans annually collect audited HEDIS data on process measures such as whether patients receive certain preventive screenings and some outcome measures, such as hemoglobin levels for diabetics and cholesterol control after an acute cardiovascular event.

In addition, plans participate annually in the Consumer Assessment of Health Plans Survey, known as CAHPS. The CAHPS data reflect health plan members assessments of the care they receive, their personal doctor and specialists, the plan's customer service, and whether they get the care they need in a timely fashion. While HEDIS and CAHPS scores have been improving, there are still plenty of room in the measures for further improvement.

You just really went over all this in the ESRD talk.

MR. HACKBARTH: As opposed to going over the same

terrain, are there unique issues? Different issues raised by payments for quality in the area of private plans that we didn't touch on in our ESRD discussion?

DR. NEWHOUSE: I wonder what we mean in the context of PPO plan, where the traditional issue has been we can't control things. I just raise it as a question.

DR. HARRISON: I believe the PPOs plans report most of the same HEDIS and CAHPS data. There may be a couple of exceptions in the HEDIS data.

DR. NEWHOUSE: So what the PPO plan, what we would want them to do would be to contract, limit their network in some fashion to providers that performed well on the HEDIS measures? Isn't that their only real instrument?

DR. HARRISON: Think it is as financial incentives or other ways of managing care.

MR. HACKBARTH: Currently aren't PPOs treated differently, in terms of expectations for quality improvement than the coordinated care plans?

DR. HARRISON: I believe they are different for quality improvement.

MR. HACKBARTH: I'm pretty sure that's true.

MS. MILGATE: The difference, as Scott said, is

actually fairly minor, in terms of the HEDIS reporting. They have some exceptions for data that would need to come from medical records, for example, but there are a lot of HEDIS measures that are administrative data that they do report on. So there's some minor exceptions in reporting. And then the current M+C requirements also don't require them to show sustained quality improvement on the national project, which is something that the other plans have to show, the coordinated plans.

DR. NEWHOUSE: That's what I was thinking of but I thought that was because the PPO plans argued they didn't have the same degree of control.

MS. MILGATE: It was actually -- yes, that was a piece of it for the quality improvement exemption. But CMS still felt like it was possible for them to improve on some of the measures in HEDIS and it has caused some improvement in the HEDIS measures that the PPOs report on. And there are other ways that PPOs can do it other than limiting networks, that some of them have used. Like directly to the consumer to get a mammography, for example, or some other method. But it is a reasonable point that there are some differences between HMOs and PPOs.

MS. ROSENBLATT: Two things. One, to add to what Joe said, is private fee-for-service within this recommendation?

DR. HARRISON: Private fee-for-service, I believe, is still exempt from reporting and they're exempt from a few other things, too.

MS. ROSENBLATT: Say you're exempting it from here?

DR. HARRISON: I guess, at this point we would have to, unless the law changes. I guess that's something for discussion. What would we want to do?

MR. HACKBARTH: I don't think we can hide behind what the law says. We're about recommending what the law should be. This different type of plan issue is just maddeningly complex. It's almost metaphysical, because we have these legalistic definitions of what organizations are, but in fact it's a real continuum and there are not clear lines distinguishing one from the other.

The conceptual distinction that exists in my mind, but it's not embodied in low, is some types of plans basically reflect a choice by the beneficiary to say I don't want somebody else making decisions for me about which

provider I go to. I don't want somebody interfering in my physician/patient relationship. I'm a choice advocate.

And if that's the sort of arrangement we're talking about, as in the case of private fee-for-service, then holding them accountable for improvement and intervening is contrary to what the product exists for. It's contrary to the very purpose of it.

Whereas somebody that enrolls in a closed system has elected I'm going for a plan that's going to intervene in the provision of care on my behalf, and holding them accountable for how well they do that is entirely legitimate.

So that's the broad distinction that I think exists. But legalistically it isn't easy to put everybody into those two categories for purposes of incentive payment or mandates about quality reporting and improvement. So it's a sticky wicket.

MS. ROSENBLATT: I have one other issue that we sort of touched on when we were talking about the ESRD, which is where does the money come from for whatever we do on the incentive rate? Are you taking away or is it an add-on?

When health plans generally add a quality incentive, it's generally an add-on to what they are already paying providers. And if, for example, Wellpoint were to make a decision to pay a quality incentive, the minute we made that decision we'd have to put up a reserve for that and that money would be there.

My concern with the way the budget works is that it's not like there is a fund and the money is there. I just can't picture that and I'm just wondering if we need to address that.

DR. HARRISON: I think that's also a decision up for discussion.

DR. WOLTER: Glenn, I was just going to make the point you did, and it might be worth reflecting that in he body of the conversation, that there are some distinctions going on with these different types of plans in terms of the market forces that are driving choice, versus a plan that really is -- maybe the expectation is out there that it will try to do more to coordinate care.

And then I would also say that we might want to recognize the fact that, at least as I look at some of what's happening in quality right now, much of the emphasis

is on process measures of intervention which aren't captured by claims data. Many of the things you mentioned are. Some, such as the amount of time it takes for an antibiotic to be given when somebody's admitted with pneumonia, or is an antibiotic given within one hour of surgery, many of those data elements would not be well captured in administrative claims data.

And yet, they are becoming the focus some of our leaders in the quality movement in some of the areas where we can really improve quality outcomes and maybe improve cost at the same time.

So I don't know whether we want to get to that level of detail, but I think these are important distinctions and probably would be part of our discussion tomorrow on the quality chapter.

MR. HACKBARTH: Could you just briefly address, Scott, the data collection mechanism for the HEDIS measures? It isn't dependent or based exclusively on claims data.

DR. WOLTER: I assume plans could require other things, also.

DR. HARRISON: I don't believe -- I believe it's a survey that's often done.

MS. MILGATE: HEDIS is a mix of administrative data and medical record extraction. The two primary reporting tools are HEDIS and CAHPS. And CAHPS, of course, is a survey. And that goes to both PPOs and HMOs. I don't know actually if it's private fee-for-service, to tell you the truth. But it definitely goes to PPOs and HMOs. And then Medicare fee-for-service outside of Medicare+Choice.

HEDIS is a mix of administrative data as well as medical record abstraction. CMS just recently, for the last few years, have been doing an analysis of the parts of HEDIS that, in fact, don't work very well for PPOs. There were a few, and I'm not going to be able to tell you how many out of how many measures. But it was a fairly -- it wasn't more than maybe 10 percent of the measures that they didn't think PPOs should have to collect data on. And those were the ones that were medical record abstraction.

And those data go -- let's see, I'm thinking they go to NCQA. I'm not sure if they go directly to CMS or NCQA, but there's an audit process, is basically what I'm trying to get at. Maybe, Nancy-Ann, you could even fill us in.

But there's an audit process to make sure that

those data that are reported by the plan are accurate and that's an independent audit, and then the data become CMS data.

MR. HACKBARTH: That was the point that I wanted to get to. We're not talking about using claims data or administrative data exclusively. There are clinical data involved but there is an audit process in place, which I don't understand, but that there is one in place.

MS. MILGATE: I don't really know the details of it but I know that the CMS actually certifies --

MR. HACKBARTH: It's a pertinent question because here now we're talking about potentially adjusting payments based on data submitted by plans. And ordinarily we like the comfort of having some sort of a potential audit check on that accuracy.

MS. DePARLE: I do know something about that. When we first started collecting it in '97, we couldn't use it because we did an audit and it had not been audited before and it was pretty uniformly incorrect in the plan's favor. So we decided we couldn't report that data. So we went through a process with NCQA and the next year we had an independent audit.

And I don't even remember who the firm was that was being used. It doesn't matter, and they may use a different one now. But I think it's an important thing.

And the plans are very corporate in that process.

DR. REISCHAUER: I think NCQA now has an audit process, number one.

Number two, the Medicare+Choice HEDIS panel doesn't include all the questions that private plans. So it's a pretty truncated subset of the information that NCQA collects for just commercial plans.

DR. WOLTER: I'm wondering if it would be a reasonable request to get to some kind of a summary of what is collected in the combo of those two things? Or is it so voluminous it would be difficult to do?

MR. HACKBARTH: Absolutely. I think that's important to have.

DR. REISCHAUER: It's apt to be on the website, too.

MR. HACKBARTH: Any other questions or comments?

DR. WAKEFIELD: Sorry, Glenn, I think somebody answered this, but the answer was lost on me.

Does draft recommendation three apply to private

fee-for-service or not?

DR. HARRISON: That's up for discussion. What do you think?

DR. WAKEFIELD: So you haven't dealt it in or out in your preparation?

MR. HACKBARTH: Do you have a preference? And if so, why?

DR. WAKEFIELD: What would be helpful to me is a little bit of a better understanding of how it could be applied to that particular animal. You were talking about choice. Of course, a lot of areas that have fee-for-service, maybe they have private fee-for-service. They may not have any other M+C available to them.

So when we think about quality, ensuring quality for that beneficiary set, even though we're seeing some retraction, but I think your document said that there are some new private fee-for-service plans that have requested review by CMS to enter the program.

So if that's the case and we see new plans coming on deck, is this recommendation going to be applying to that enlarging family or not of plans? I don't have a sense of it because I don't exactly know how it would apply to that

type of plan.

MR. HACKBARTH: Let us spend some time thinking through the issues a little bit for the January meeting and we'll come back with some ideas on that. Anything else?

Okay, we're going to have a very brief public comment period and then adjourn for lunch. As always, please help us by keeping your comments short. I assure you that you get more attention if you keep it brief and to the point than if you go on. If someone in front of you has made the same points or similar points, please be cognizant of that and adjust.

MS. GAMBEL: Gwen Gambel, President of Congressional Consultants. We represent a number of dialysis-related clients.

I think this was the very best discussion I've seen and I've been watching these meetings since ProPAC began. Your level of knowledge has really increased and the questions asked of Nancy, and the overall discussion, I think has really improved. That was just a quick aside.

Getting to the points. We really would urge you to use the CMS market basket rather than this jerry-rigged one that was put together by ProPAC so long ago when there

was so much less data. The market basket that CMS put together was put together by the same actuaries that put together every single market basket, hospital, et cetera, since CMS created market baskets or HCFA created market baskets.

It has more input factors to it. It has better proxies. And it really is such a better reflection. I can't even understand why you would want to continue to use one that was so jerry-rigged with one-third home health, one-third SNF, one-third hospitals, the labor factors projections when labor is 40 or 50 percent of costs. So we really hope that you will seriously consider using that.

Secondly, I think the industry would be willing to consider -- and I say consider -- being paid on quality incentives but clearly not on a budget neutral basis. And that's because we are absolutely inadequately paid. As Dr. Rowe pointed out, we haven't had an update in 13 years. Our first update will come in 2005, a measly 1.6 percent, which is a little over $1 per treatment. We're not talking big bucks here when we're talking about these increases here.

We are really very, very disappointed about this continued effort to have a productivity offset. As a

conditions of coverage we have nutritionists, a dietitian, social worker, and this is wonderful. These are important people in facilities. They are absolutely stretched to the limit. You never find a dialysis facility with more than one social worker or one nutritionist. These are so important for patient outcomes.

Nutritionists sit down with every patient every month and goes over their blood lab results and this is the way to educate the patient so that they will be more compliant and you will have better outcomes. And these people are just stretched to the limit. So this is really very bad for patient outcomes if you keep saying that there's this room for productivity offsets.

The same with the social workers. The social workers have to make sure that the patients get their meds, they have to make sure that there's transportation for these patients so they don't miss their treatments. These are such critical people for patient outcomes. And yet, we only have one of them in each facility because of this inadequate reimbursement. So please think about these productivity offsets.

And then we are really the only provider without

an annual update formula? And where's the justification for that? I mean, would you think about hospitals not having an annual update formula as part of their reimbursement? Clearly not.

But we have to compete with these hospitals for our nurses and for our technicians. We have provided Nancy Ray with around the country where dialysis facilities versus hospitals on what is paid and bonuses. Clearly, hospitals can pay on average $5 to $10 more an hour for a nurse. That's a no-brainer where the nurses are going and why we have shortages and why the GAO highlighted the fact that we have nurse shortages.

So we would urge you, please think about an annual uptake recommendation in your recommendations this year, because there's really no justification for us being the only provider without an annual update formula.

Lastly, when we get to the adequacy of the payment, we have provided on the table for you 2002 cost report data which unfortunately Nancy did not get from CMS. We had 70 percent of dialysis providers with their cost reports providing 2002 data to Abt Associates. When Abt Associates took that cost report data, they projected that

based on 2002 cost reports, our margins are 0.70 and our payment-to-cost ratio of 1.003. This is total costs, composite and drugs, on just the allowables. When we start looking into some of the non-allowables, like full medical director fees, we're below zero everywhere, margins as well as payment-to-cost ratios.

So we're hoping, we see you're thinking about just a 1.6 recommendation for 2005. Our projections show really a 3.6 percent increase is needed. And again, it's in the handouts. And I urge you to pick up the handout so that you can go over those numbers.

Thank you very much.

MS. SMITH: Good afternoon, my name is Kathleen Smith and I'm the Vice President of Government Affairs with Frizentius Medical Care. We're the largest supplier of items and services to beneficiaries with end-stage renal disease.

I once was the President of the Fast Talkers of America, Dr. Hackbarth, but I think your Commissioner, Dr. Wakefield, has got me beat. But I think I can still manage to be brief.

We have followed with interest over the recent

years and provided information with regard to end-stage renal disease payment reform. And given the Commission's history on that subject, and the fact that the recently passed Medicare legislation does advance that process, I would like to urge the Commission to make a third recommendation in your report this March addressing that topic.

Specifically, we urge the Commission to affirm its recommendations to Congress that the need for accuracy and transparency in rate setting in any new payment mechanisms and to recommend that CMS reevaluate the difference between and the relationship between current treatment costs and payments. Specifically including the validity of outdated cost report rules which result in the arbitrary disallowance of certain truly necessary treatment-related costs.

As part of any serious reform effort it is important that the baseline composite rate be revised to reflect the full cost that we incur in furnishing dialysis services. And further, that the rate be updated annually, using a mechanism similar to the one that CMS just recently developed as Ms. Gambel just commented comment on.

There is a precedent for taking this type of

position in payment reform and many of you lived through this and remember it, but just by way of recollecting, when the hospital PPS was implemented, hospitals were subject to certain TEFRA-related cost limits. Those limits were removed, however, in calculation of the PPS base rates. And what I'm here to ask for is that something akin to that be part of the ESRD payment reform mechanism.

I thank you for the opportunity to make these comments.

MR. CINCHANO: Good afternoon. I'm Dolph Cinchano, Vice President of the National Kidney Foundation.

As has been mentioned in Nancy's remarks and remarks around the table, the National Kidney Foundation Guideline Development Program is emblematic of our concern for improving the parameters of care, not only in adequacy of dialysis and anemia management, but also with respect to nutrition, vascular access placement and preservation, and in the area of bone disease.

I'd like to point out however that the performance of dialysis facilities is not the only factor with regard to outcomes in those three particular areas. With respect to nutritional status of dialysis patients, the compliance with

dietary restrictions is only part of the issue. The other half of the concern has to do with malnutrition, which is a severe problem among dialysis patients and is implicated in the hospitalization patterns of dialysis patients.

Dialysis facilities have limited ability to impact on malnutrition. Medicare does not pay for most dietary supplements and the Medicare policy for the most extreme form of dietary supplementation, nutrition that is provided during dialysis treatments is so restrictive that virtually no patients qualify for it.

Similarly, the vascular access placement decisions are made and should be made before the patient comes within the care of a dialysis clinic. The National Kidney Foundation Guidelines call for an increase in fistulas, that is native vascular access, a decrease in grafts, and a decrease in the use of catheters for vascular access.

Interestingly enough, Medicare payment, however, provides an incentive for the use of graphs as opposed to fistulas. So this is an area that perhaps the Commission could address with respect to Medicare payment for vascular access placement.

Finally, with respect to comments from Senator

Durenberger, the National Kidney Foundation and its 26,000 patient members are dedicated to empowering patients. But one way to empower them is to provide them with additional education opportunities. So we have been championing a provision to create a new Medicare benefit to educate kidney patients about their treatment options and their role in the treatment process, and to do this education before they ever come within a dialysis clinic.

There was a provision in S.1 which would've created that benefit. It did not survive the conference, however, so we will continue to advocate for that new benefit.

And then lastly, with respect to whether or not ESRD patients should be able to enroll in managed care plans, we have traditionally opposed repeal of Section 1876 and, in view of the fact that that we have yet another demonstration project that CMS is sponsoring which could shed light on the value of disease management and managed care for dialysis patients, I would recommend that legislative change be held in abeyance until we see the outcomes of that study.

Thank you.

MS. COWAN: Hello. Never wanting to stand between hard-working people and a meal, I'll be very brief.

I'm Joyce Cowan from Epstein, Becker and Green, and I represent Amsurg. So shift gears for a minute and think about ambulatory surgery centers, which will be on your plate tomorrow.

We've provided comments to the Commission in the past and really appreciate the opportunity to do so today.

Amsurg is a large national company operating and managing ASCs, over 110 in 28 states. So we think we'll have a lot of experience that will be helpful as the Commission goes forward in continuing to look at this important area. I'm sure you'll be thoroughly briefed tomorrow on the changes that Congress has made in this area since your last set of recommendations last year. And I think it brings a really exciting opportunity for MedPAC to dig in and look at some of the complex issues with ambulatory surgery centers.

In short, the Congress did three things, basically. They more or less froze payment for the five years. Two, they asked the GAO, if you recall from last year's discussion, we've had a real shortage of data, direct

hard data, on ambulatory surgery centers charges, costs, how they compare to hospitals, et cetera, et cetera.

So GAO will be looking directly at that and a number of other issues with an end result game plan of Congress giving HHS the authority to revise completely the current payment system for ambulatory surgery centers, that roll-out to be expected after the GAO report, somewhere between '06 and '08.

So what we would urge the Commission to think about, to help Congress plan to help HHS plan for that '06 to '08 roll-out. There are a lot of really complicated questions in this area. What do we know about ASCs, how large does Medicare payment policy, how large is that role affecting ASC growth, practices, et cetera? Why are private payers big fans of ASCs in many instances? A lot of really intriguing questions that end up affecting, I think, Medicare payment policy.

At Amsurg, with over 110 centers, we'd love to be able to provide whatever experience. We've offered up some of our local sites to staff to come out and visit and get your hands around what's going on in ASCs.

I want to let you get to lunch, so I really

appreciate the opportunity to give some comments.

MR. HACKBARTH: We will reconvene at 1:30.

[Whereupon, at 12:42 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:51 p.m.]

MR. HACKBARTH: Cristina and Kevin, I think we're going to go ahead. We'll have the remainder of the commissioners coming shortly.

MS. BOCCUTI: Good afternoon. Kevin and I will be presenting an assessment of payment adequacy and update considerations for physician services. To help the Commission consider its recommendations for physician payments we will summarize the available evidence on adequacy of current payment. Kevin will present two pieces of this analysis. First an analysis of volume growth and also a comparison of Medicare payment to private insurance payment. Claudia Scherr is with us today and she's going to be available to answer some questions on a new survey which I'll be telling you about in a little bit. We're also going to discuss expected cost changes and a draft recommendation.

To examine beneficiaries access to physician services we consider several information sources. Surveys that ask beneficiaries directly about their access to care, data on physician supply, particularly with respect to physicians who treat Medicare patients, and surveys that ask physicians directly about their willingness to serve

Medicare beneficiaries. Overall, from surveys between 2000 and 2003 access is generally good for beneficiaries. A small share of beneficiaries, however, do report some difficulties obtaining access to physicians.

A large survey, the CAHPS fee-for-service survey, provides some insight on beneficiary access to physician services. The details of this survey will be discussed tomorrow morning but I'm going to highlight a couple results specifically dealing with physician access. Those results are on this slide here. Beneficiaries are asked on the survey if they have had problems seeing a specialist and 94 percent of beneficiaries said that they had small or no problems seeing a specialist when necessary. Asked about timeliness of scheduling an appointment for regular or routine care about 90 percent said that they usually or always received care as soon as they wanted. Note that this survey gives us information only up to 2002.

To obtain more timely data MedPAC has begun sponsoring small telephone surveys to beneficiaries. This project is managed by Project HOPE which is where Claudia helped us, and we have received results from an initial round of this survey. We think of these results as giving

us some baseline information. I'm going to take a moment to describe the survey since it's the first time we've used it. I'm going to talk about the goals and limitations, but Claudia Scherr is here to answer some technical questions if they arise.

This survey is an attachment of a set of questions to a larger consumer telephone survey conducted by a survey research company. The survey includes a core set of demographic questions in addition to questions sponsored by other organizations. We sponsored 13 questions. The survey was conducted recently, between September 17th and October 2nd, 2003. It took about three weeks to obtain a little over 1,000 respondents who were Medicare beneficiaries age 65 or over.

The goals of the survey for us were to help us obtain baseline results from its initial implementation and then future rounds to give us an ability to monitor beneficiaries' access to physicians services. But due to sample size and response rate limitations a comparison to other larger government-sponsored surveys with longer field period may not be possible. So our analysis is cautious and we see this mostly as a monitoring tool. The major

advantage of this survey is its timeliness and low cost. Additionally, we can use this survey to assess beneficiary response to other Medicare policy issues in the future.

So now I'll share some results from the survey. These results are weighted to be nationally representative with respect to basic demographic variables. So on the slide you can see that we asked about beneficiaries' ability to find a new primary care doctor. Ninety-three percent of beneficiaries who were seeking a new physician reported that they encountered small or no problems and only 7 percent reported that they encountered big problems or were unable to find a doctor. When asked about access to specialists, similarly, 93 percent of beneficiaries who tried to find a new specialist reported having small or no problems finding one, and 5 percent reported big problems or were unable to find a new specialist.

When asked about routine care and whether or not they experienced delays in trying to schedule an appointment, 71 percent of those beneficiaries who tried to schedule an appointment for routine care never experienced a delay, or that's what they reported; 21 percent said sometimes and 8 percent said that they usually or always

experience a delay. For illness or injury-related needs, beneficiaries' ability to schedule timely appointments was better. Specifically, 80 percent of beneficiaries who tried to schedule an appointment for an illness or injury never experienced a delay, 16 percent sometimes and 4 percent said they usually or always experienced a delay.

Because we're only interviewing Medicare respondents this survey and all other ones that only interview Medicare respondents, don't offer a comparison to other insured populations across the United States so it's difficult to determine whether or not access concerns for some beneficiaries are unique to their Medicare status. For example, market area trends in physician availability may play a role in Medicare beneficiaries' ability to find doctors and receive timely appointments. On this point, older research from the Center for Studying Health Systems Change found that between 1997 and 2001 both Medicare beneficiaries and privately insured near elderly, -- that's people between the ages of 50 and 64 -- encountered growing rates of access problems. Results from this study were discussed in our report last year.

Next I'm going to talk about some supply issues,

looking at supply issues that affect beneficiaries' access to care specifically. Usually we provide you with updates on the number of physicians billing Medicare. However, CMS is in the process of re-examining their data on this so we're unable to give you this information today for 2002.

But in using slightly less direct indicators of the supply of Medicare physicians I've put up a chart here that shows the share of physicians signing participation agreements and the share of allowed charges paid on assignment over time. In 2002, 99 percent of allowed charges for physician services were assigned. That is, for 99 percent of allowed charges physicians agreed to accept the Medicare fee schedule charge as the full charge. This high assignment rate indicates that fee schedule amounts may be adequate, at least when associated with the additional benefits physicians receive when accepting assignment. This high assignment rate may also reflect the high rate of physicians who agree to participate in Medicare, which was 91 percent in 2003. Participating physicians agree to accept assignment on all allowed charges in exchange for a 5 percent higher payment on allowed charges than non-participating physicians.

We also examined physician surveys that provide information on the proportion of physicians who are accepting new Medicare patients into their practice. In general, the most recently available data indicate that most physicians are willing to accept new Medicare beneficiaries, particularly those with a relatively large portion of Medicare patients in their practice.

Smaller share physicians who report a reluctance to serve Medicare beneficiaries may be responding to a variety of factors other than or in addition to payment adequacy. These other factors may include administrative burden of Medicare, local physician supply, demand for physician services, area market insurance conditions, and the amount of time physicians are willing to devote to patient care. So it's difficult to disentangle these factors given the availability. Consequently, we're often limited to physician responses to simple questions regarding whether or not they are accepting Medicare patients.

The most recent survey information comes from the National Ambulatory Medical Care Survey, or NAMCS as we often call it. This survey is conducted in 52 reporting period during the year, so that ensures that it's capturing

an even spread throughout the year. Results from this study show that 93 percent of office-based physicians with at least 10 percent of their practice revenue coming from the Medicare accepted new Medicare patients. This number is not significantly different from those reported on the 2001 NAMCS. We're hoping to get 2003 results in January.

Moreover, this finding is consistent with the results of the MedPAC-sponsored survey of physicians that Kevin talked about last year, and that was conducted in 2002. Ninety-six percent of physicians in that study who were accepting any new patients and who spent at least 10 percent of their time with Medicare patients were accepting new fee-for-service Medicare patients. But a you may recall, the percentage accepting all new Medicare patients was lower at about 70 percent. Earlier research from the Center for Studying Health System Change showed that the proportion of physicians accepting all new Medicare patients fell at about the same rate as that for privately insured patients.

Next is Kevin.

DR. HAYES: One other indicator that we look at of the adequacy of Medicare's payment rates for physician

services is changes in the use of services by Medicare beneficiaries, changes in the volume of services. The thought here is that if we see decreases in volume that could be a sign that Medicare's payment rates have become inadequate. As we look at claims data through 2002, however, we do not see decreases in volumes, at least among the broad categories of services shown here. In fact we see some pretty strong increases still in a couple categories of services, as we have seen in the past, and that would be in the categories of imaging and tests. On a per-beneficiary basis the volume of imaging services went up by 9.4 percent in 2002, and for tests the increase was 11.1 percent.

Within these categories we do see some decreases in volume for selected services but it's not clear that the decreases are a sign that payments have become inadequate. In general, the decreases that we see are quite small or they follow rapid increases in previous years. One exception to all this would be a service like coronary artery bypass grafts, however, and there the decrease was just over 4 percent in 2002. Our interpretation of what's happening there that we're just seeing some substitution of the less-invasive coronary angioplasty procedures for the

more invasive open heart surgical procedures.

So bottom line on this indicator would be that we don't see any evidence that the payments have become inadequate.

If we look at our last indicator of payment adequacy, this is something that we looked at last year. if you recall, comparing Medicare's payment rates for physicians services with average private insurers' payment rates. The thought here is that if Medicare's payment rates get too far below those of private insurers that some physicians may choose to limit their practices to private patients and not take Medicare's patients.

For this year we contracted with Chris Hogan at Direct Research to update previous analyses to use claims data through the year 2002. Recall in previous analyses we ad shown that the difference between Medicare's payment rates and those in the private sector had narrowed. This was through 2001 at a time when Medicare's payment rates were growing at a relatively rapid rate.

In 2002, we see some slight widening of the gap between Medicare and private rates. The figure for 2002 is 81 percent. So we're going from 83 percent in 2001 to 81

percent in 2002. The reason for this, a good part of it has to do with the payment reduction that occurred in Medicare's rates in 2002. Recall that the conversion factor fell by 5.4 percent in that year.

The gap would have been wider if not for a few other things that happened. For one thing, Chris found in analysis of the private data some drop in average private insurers' rates. This was primarily due to a shift of private enrollment from more generous-paying indemnity plans toward other lower-paying types of plans.

Other factors at work here include the fact that when we look at physician services we're including in the definition of them not just physician fee schedule services but also Part B drugs and laboratory services, and those services did not experience the decreases that the physician fee schedule services did in '02.

Finally on the Medicare side, there were some offsetting increases in relative value units in the fee schedule which slightly muted the effect of the conversion factor change.

But anyway, putting all this together, we do see some slight widening of the gap between Medicare and private

rates, but we're not by any means at the point we were in the mid-1990s. As you can see here, the gap was much wonder where Medicare's rates were more in the range of 60 to 70 percent of private rates.

MS. BOCCUTI: I'm going to take you into the second part of our adequacy payment framework, which is changes in cost for 2005. There's two factors that are important here, the input price inflation and the productivity growth. The preliminary information on input price inflation from CMS for 2005 shows an increase in input prices of 3.2 percent. Within that total, CMS sorts the specified inputs into two major categories: physician work and physician practice expense.

Physician work includes salaries and fringe benefits allotted for physicians, and that's expected to increase by 3.4 percent. In the physician practice expense category, what's included there are the non-physician employee compensation, office expenses, professional liability insurance, drugs and supplies, and medical equipment. That is expected to increase by 2.9 percent for the whole category. Within that, the PLI is expected to increase by 4.7 percent.

As you know, to calculate these increases, CMS uses weighted averages. Recently CMS rebased its input category weights. These calculations resulted in a decrease in the share of revenues going towards the physician work component and an increase in the practice expense share with an increase in PLI.

The other factor that we consider here is productivity growth. Our analysis of trends in multifactor productivity suggest an increase of 0.9 percent. We'll put these two numbers together, the input price, inflation, and productivity growth numbers in just a moment.

So to recap what we've said so far, we determined that payments in general have been at least adequate though some access problems may exist for some beneficiaries.

Now to discuss a draft recommendation for our report, and this applies to the year 2005. In order to determine payment adequacy in 2005 we need to make some assumptions about payments in 2004. As you know, Congress has acted to prevent a payment cut in 2004 and accordingly payments in 2004 are likely to be adequate.

So the draft recommendation here is similar to the one in the previous March 2003 report. That says that the

Congress should update payments for physician services by the projected change in input prices less 0.9 percent in 2005.

To discuss the implications on beneficiaries and providers, increasing payments for physician services would help preserve beneficiary access to care. And increasing payments to physicians would help to maintain the adequacy of those payments and allow physicians to furnish high-quality care.

Having recently received CBO's budget estimates for the new act, we do not feel that we can confidently predict the budget implication compared to the legislation, so we will present budget implications of the Commission's draft recommendation at the next meeting.

Thank you.

MR. HACKBARTH: Just for context can I ask you to go over briefly the provisions in the reform legislation? In fact let me ask you to just react to this characterization. As I recall it was a 1.5 percent update for each of the two years and then there were a series of changes in some other provisions affecting physicians, many of them directed as rural physicians, increasing payments to

rural physicians. Do we have a sense of what the aggregate effect of the update plus the other provisions was in terms of the total increase in payments, and how it would compare to our recommendation?

MS. BOCCUTI: I'm going to turn that over to Kevin who's been investigating some of that right now.

DR. HAYES: Relying on the CBO scoring of those other provisions, they represent a total somewhere in the area of less than 1 percent of total spending. So if we couple the 1.5 percent increase in the conversion factor with those additional more targeted spending increases we're looking at a total increase in spending for physician services somewhere in the 2.3 percent, 2.4 percent area.

MR. HACKBARTH: The aggregate effect of what Congress did would be very similar to the effect of our recommendation in terms of total spending but they've chosen to distribute the dollars differently?

DR. HAYES: Yes.

DR. STOWERS: First I think it was a great chapter. There was one thing or a couple two or three things. One was this assumption that if physicians accept assignment, or participate, or don't balance bill inferred

that that meant that they were satisfied with the payment or whatever. I think I would make the case that the majority of them accepting assignment has nothing to do with whether or not the fee schedule is adequate or inadequate. It has more to do with the incentives that are built into whether to accept assignment or not accept assignment. The only docs that do not accept assignment or those that are in affluent enough areas that their patients can pay the bill up front in those practices, because if they don't then the patient has to pay the bill up front in the office because the check is going to come from the Medicare at a much delayed rate, sometimes two to three months later because Medicare is not obligated to get the check out in a certain period of time. Then the physician has to go collect the money then later from the patient, and it's at a reduced rate and you'd have to go through all of this trouble, and in the end the physician ends up with less money in the end. Just all the collection problems and all the other things that happen. So that's why 98 percent of physicians accept assignment. It has virtually nothing to do with the payment schedule being enough or too little or too much.

So I really think it's an inappropriate confusion

of whether or not Medicare is paying enough or too much for services in this chapter, as to whether or not physicians are accepting assignment or not. It's all these other incentives, in other words, that are forcing --

MS. BOCCUTI: Right, the additional benefits.

DR. STOWERS: The incentives have been built in there by Medicare for many years to force docs into accepting assignment. It has nothing to do to with --

MS. BOCCUTI: And I didn't even mention all the additional benefits. I did in the chapter, I tried to. So I will make that very clear, that there are added benefits that may be weighted heavily in a physician's decision to accept assignment.

DR. STOWERS: I really question whether this accepting assignment ought to even be in this chapter at all. Because we're looking here at the adequacy of payment in Medicare and I don't see a place in the chapter for accepting or not accepting assignment.

MR. HACKBARTH: So from your prospective it goes more to the question of beneficiary liability, and it has an effect there, but it doesn't reflect that the Medicare payment rates are adequate.

DR. STOWERS: Right, it has nothing to do with that.

DR. HAYES: If I may, it would just be that we have traditionally used this indicator as a complementary indicator with the information that we don't have yet, admittedly, on the number of physicians billing the Medicare program. So when we put all of this together we have a picture of whether or not physicians are continuing to accept Medicare patients and an indication of what the financial liability is what for the beneficiary, which is an indicator of access, which we do consider access as one of our payment adequacy indicators here.

So in the interest of putting together a complete picture of what it's like for the beneficiary to make use of physicians services we felt like there was some value in putting it in there.

DR. STOWERS: I'm okay with what's in the box that says, it may have something to do with the balance billing part and the access to the patient and that's truly pretty insignificant because it only makes up 1 or 2 percent of the physicians out in the field. But then you turn around and made the statement that because most of the physicians

accept assignment than the payment rates must be okay. That statement I feel is -- that's an inappropriate --

MS. BOCCUTI: The conclusion is what --

DR. STOWERS: That conclusion is inappropriate because there's lots of other things driving the fact that physicians accept assignment versus going the non-assignment, rather than the fact that they're being paid enough by Medicare.

Nick might have other thoughts about that than I do. So I just don't think we can jump to that conclusion.

MS. BOCCUTI: I understand.

MS. ROSENBLATT: I just want to ask a question about the Chris Hogan survey and the graphs that you showed that was about 80 percent. That's based on actual claims data and it's based on comparing Medicare fee schedules to what a private insurers might pay an under-65 population most likely, correct? Refresh my memory, does that include capitated payments? I wouldn't think so. Or does it?

DR. HAYES: Yes, there are HMO claims on the private side.

MS. ROSENBLATT: HMO claims, but not capitation.

DR. HAYES: No.

MR. HACKBARTH: So it's just payment -- fee-for-service claims.

MS. ROSENBLATT: There's no capitation in there?

DR. HAYES: Correct.

MS. ROSENBLATT: So if it's HMO, it's an HMO that's paying on a fee-for-service basis?

DR. HAYES: That's correct.

DR. NELSON: I may have misunderstood what you said but with respect to the 2004 update I think you said that Congress has legislated a small update so we assume that payments were adequate for '04 in projecting for '05?

MS. BOCCUTI: Right, in that what Glenn was bringing up earlier in getting a sense of aggregate payments. But before the act there was a pay cut that was slated to occur.

DR. NELSON: I understand all that. I guess the point that I want to make is that we came up with a recommended update for '04 that was based on inputs less a productivity factor and Congress's actions ought not to necessarily negate that, at least until we have experience that tells us whether that update was adequate or not. The presence of legislation that may redistribute that within

various portions, rural versus urban or whatever, doesn't detract from the fact that that indeed may not be an adequate update for large portions of the population receiving services. Until we can develop some data on '04 I wouldn't want to see us assume that that was an adequate update until we know that it is.

Even reflecting on '05, I think we ought to be consistent with the same process and try and estimate as accurately as we can what the input costs will be, less a productivity factor, which I've never agreed that we use the right metric for that. I wonder if there is a productivity for the service industry as opposed to industry that produces products, in labor statistics. I don't know that, but I'd like to find a way to refine the productivity better than just taking a shot at 0.9. But that's a different issue.

So the point that I want to make is, let's word our recommendation for '05 so that our reference to '04 is consistent with what our recommendation has been and the process that we followed in arriving at it.

MR. HACKBARTH: Maybe we ought to jump ahead and just look at the language --

MS. BOCCUTI: The background that I said on 2004 -- 2004 is not necessarily in the draft recommendation. That's background.

MR. HACKBARTH: Right. So based on the measures of adequacy that we review, we have no data suggesting to us that what was done in '04 was inadequate. On the other hand, we have no information, as you're pointing out, to specifically bless it as adequate. So we're silent on that and the recommendation language is directed only towards '05.

MR. MULLER: If we could go back to the chart that compares the physician -- thank you.

In some of our other provider chapters we often make a comparison of Medicare margins versus total margins and I think as a policy we have basically said that we should not use the Medicare program to support margins that are less than adequate from other payers. I think it might be useful -- this is obviously a provider sector in which the Medicare program pays less than the private market, though I'm sure if we had a Medicaid slide up there it would show it pays more than Medicaid on average.

But I think for the sake of consistency it would

be useful to show that in fact this is one area in which, if one could use such a margin calculation -- we don't do it as much with physicians as we do with other providers because of the difficulty of calculating physician margins -- but this is an area in which Medicare in a sense could be said to pay less than the private market. We in a sense have a higher margin elsewhere and one could -- what I'm suggesting is it's the total margin elsewhere that is supporting the Medicare margin being less. I think if we're going to make that point consistently in those areas where the Medicare margin is higher than what is paid by private payers and other providers sectors, I think we might want to suggest the reverse here. That in fact there is some support going on of physician income from the private payers. I wonder, Kevin, if you want to comment on that.

DR. HAYES: I don't know about support of physician income without knowing the unknowable, which is what their costs are. That's the difficulty that we face in this sector is not having a good measure of costs. So I don't know where Medicare is relative to their costs otherwise. So our goal here with this has been, as you can see with this slide, is to just look at trends over time and

see how Medicare compares to the other payers. But implicit in this is a recognition that we can't get at that further issue of the cost comparison.

MR. HACKBARTH: In fact I think I would be uncomfortable with the notion of saying this slide shows some cross-subsidization of one payer by another. I think the relevance of these data are -- we're looking for potential harbingers of access problems for Medicare beneficiaries. The notion is that if these numbers get too far out of whack it could be a harbinger that problems are on the way for beneficiaries. So it's an indicator that we're looking at as opposed to a commentary on the relative subsidization of one payer by another.

DR. REISCHAUER: Let me jump in just because I want to talk about this table here, and some of the things Ralph had said. Kevin, I guess I just didn't focus on the fact that this included, I think you said Part B drugs and lab tests. My guess is, relative to physician services narrowly defined, the fraction over time accounted for by lab and prescription drugs applied in the office have grown. The numbers are pretty small but I wonder if you could do a what-if on the weights.

I'm looking at this table that you have, and I know we discussed this before, and looking at lab tests which is an infinitesimal section of the total, but a 16.9 percent growth in one year. Bells would go off if this were bigger. I just can't imagine what's bringing about a service utilization growth in one year that is that great. We have the drug thing, as I said. This trending upward that we have could really be an artifact.

DR. HAYES: So we need to do some sensitivity analysis I guess and see want to the effect is without those other factors. Hold on one second.

DR. REISCHAUER: Don't tell me you have it.

DR. HAYES: Chris is pretty good and he did this --

DR. HOGAN: Page 5.

MR. HACKBARTH: Chris, why don't you come up?

DR. HOGAN: Good point. I wish I'd thought of it. Page 5 of the report, I took them out and it didn't make any difference in that ratio. It was almost 15 percent of the spending total when I got all the little odds and ends take out. So 85 percent of what you see up there really is the services of physicians, 15 percent is other stuff. But it

turns out the pricing differential was not all that different for the other stuff versus the physician services. Put it in, take it out, I get that last bar, that 2002 bar is at the same spot.

MS. RAPHAEL: I just wanted to share with commissioners a conversation that I had with Mark and Kevin and Cristina and some of the things that grew out of that, because I have been approached by a number of people who have been telling me that they believe in their area of the country there are access problems that are being experienced. This is all fairly anecdotal. It's not at all based on any kind of national review of the issue.

But in discussing this with Kevin, Cristina, and Mark and Bob Berenson in a conversation this week there were a number of things that I guess I hadn't been as aware of. One is that there are differences in marketplaces attributable to dependence on Medicare. Because if you're in a particular specialty like ophthalmology that is very dependent on Medicare you're less likely to reject Medicare patients than if you're in specialty where you actually can select from a broader population. I think that is something that we need to take a look at.

Secondly, one of the points that was made based on some recent information which maybe Chris can comment on, was that actually there's a broader gap between private payments for specialists and Medicare payments for specialists than there's for primary care and general practitioners, which I also had not been as aware of. I think, Mark, we agreed that we were going to take some steps to try to get at this beneficiary access issue over the next few years. But you may also want to comment on --

DR. MILLER: Just a couple of comments on this. Last year when we went through this same analysis -- and refresh my memory if I'm wrong, we did disaggregate by specialty and IM, GP types of physicians and did make this point about specialists, that the gap between the specialist payments in private and Medicare is larger than it is between the primary care and IM types. In a conversation with Bob Berenson what was interesting was that what he was finding was, or what he was arguing in some marketplaces is almost counterintuitive. That it's much easier to get access to a specialist -- and some of it is because they are very dependent on Medicare types of patients -- and that the issue, the bottleneck was more among primary care

physicians, and that some of what was happening is that the patient presents and the primary care are not spending the time to go and do the evaluation and management. It's just, your leg hurts, you go to the leg specialist. Your head hurts, you go to the head specialist. You can tell how technical I am on all this. That was the argument.

What we got into was discussions of relative payment within the fee schedule, is the longer run issue. Kevin or anybody like that should comment if there's a piece of the conversation I missed.

DR. HAYES: No, that's it. The interesting thing for me in that conversation was that there's clearly more involved than just payment rates. If it's a matter of a narrow gap between Medicare and private rates for primary care services, yet that seems to be where the beneficiaries, at least from anecdotal reports, is where they're having the most difficulty. Then you figure there's perhaps some other more macro, system level factors at work here having to do with just overall demands on the primary care physicians from all patients, not just Medicare patients. So it's a complex thing.

DR. WOLTER: Kind of a process interpretation

question related to something Alan raised, if the new legislation has, what is it, 2.4 percent increase for physicians?

DR. HAYES: 1.5 for physicians.

DR. WOLTER: If the total when you add in the GPCI and other things it's closer to 2.3 or 2.4, and our recommendation comes out at whatever it comes out at, how does that get interpreted, and do we make any comment on that? Because there could be the thought that we're right on with the recommendation coming out of MedPAC in terms of the legislation. Others might say, there was an update recommended and that should be on top of the total that's perhaps in the legislation; this distributional issue that Alan raised. Is that something we just stay silent on, or how do we deal with those questions?

MR. HACKBARTH: The reason I raised it is I think that the explanation is important. On how people will react to it I'm less certain. But I didn't want people to say, MedPAC recommended 2.3, Congress did 1.5; they're at odds. I think it's more complicated than that. Congress did essentially the same thing in terms of increasing aggregate expenditures for physician but chose a different

distribution of the payments. I don't think we're -- we could decide to comment on that distribution and say that we think Congress distributed it properly or improperly. That's an option open to us.

But the first order analysis is just that the aggregate dollars are about the same and I wanted people to understand that. I think that is an important statement for us to make.

DR. WOLTER: That was a good point. Of course another option would be that we think the update needs to be whatever it needs to be and that's a separate question from GPCI adjustments or whatever, and those would be additional dollars. There would be several options in the conversation.

MR. MULLER: We've done the physician update based on kind of a marketbasket equivalent.

DR. MILLER: The only thing I was going to say about commenting on the bill, it's happened fairly recently and whether, at least from an analytical perspective of being able to express an opinion about it would have involved a fair amount of work. First understanding it, modeling it, and determining what the distributional impacts

are, and then a discussion of whether we agreed with them or not. I can tell you for certain, our ability to do that between now and January is going to be pretty much zero. So it will be hard to make an analytical statement about whether we agree with what they've done.

MR. HACKBARTH: That would not foreclose our, in the future, looking at the GPCI changes and the like and offering an opinion on whether those were a good thing or not. But then the other side of the coin and the one I think Nick is getting at is that, arguably, you're saying that there should be a 2.3 percent increase and then the GPCI and all that stuff on top of it. That would be another way to go.

DR. WOLTER: I was just envisioning the possibility after you raised it and then Alan followed up that those might be conversations that would occur over the course of the year.

MR. HACKBARTH: I guess the way I would like to leave it is keep our recommendation framed in terms of the overall update, and I think the 2.3 percent is about the right to number. If we wish to come back and address some of rural provisions that were added I think we need to do so

in a careful and thoughtful way and January isn't sufficient time to do that. We can come back to it later.

DR. REISCHAUER: I guess I sort of have the feeling that if the 1.5 percent is significantly lower than what we suggested for a general update we should make some nod in that direction and not pretend that money that's going to be concentrated on a very small fraction of the physician population really is there to take care of the general problem that's out there. I'm not sure that we do this with sufficient precision so that when the general update is a few tenths of a percentage point below or above where we recommend that we then leap from our chairs and say, good Lord, inadequate payments; we have to do something. I think you can write this in a non-confrontational, non-judgmental way.

MR. MULLER: Glenn, just to go back to the point I was making earlier, this is a provider segment in which we do not do our usual two-part test. Basically we use measures of access as a proxy that the base is adequate. I understand why it's difficult to get a calculation of physician revenue and cost, but basically in the other sectors, whether it's home health, SNF, hospitals, et

cetera, we do make some calculation of adequacy before we do our update, and obviously here we don't. Maybe we should say, we don't do it here because it's too complicated to do, but basically use the access measure as a proxy for adequacy rather than actually calculating it.

MR. HACKBARTH: Access is a part of the framework for all providers so it's not unique to physicians that we look at access. But it is in fact true that we have no data on margins, because we have no information on physician costs. So that's an empty hole in our framework for physicians, which I think maybe makes it even more important that we look at the access number.

I also think the physician market -- I haven't thought this all the way through so bear with me. But I think that the physician market may have a little bit different dynamic than some of the other provider sectors. I think Medicare's market power is less for physicians, at least some specialties of physicians than it is for hospitals. It's very difficult for a hospital to walk away from the Medicare program, except in rare circumstances. But for some physicians and some specialties where Medicare is a very low, or a much lower share of their revenue,

walking away or not accepting new Medicare patients is much more of an option. We hear anecdotes that in fact some physicians are exercising that option in particular parts of the country.

So I think paying particular attention to how Medicare rates compare to private rates and any other indicator of access is especially important for physicians. The sensitivity may be even greater there.

DR. REISCHAUER: Kevin, I think you said that to the extent that there appeared to be difficulty in accessing care it was more with primary care physicians than with specialists. I would think that that's what one would expect because specialists have a much higher turnover of patients during a year, so in a sense there's more openings than a primary care physician who might have very low amount of turnover, so the probability of one going and seeking an open slot is always going to be less.

MR. MULLER: It's more clinical, Bob. It's basically that people who need specialists are old. I mean, 35-year-olds by and large don't need specialists. It's more of a clinical indicator -- specialists have more Medicare patients than primary care because they're the ones who need

specialists and because 35-year-olds don't need them.

DR. NELSON: They may have a rapid turnover but they may have a longer queue. But to get back, I think it's important for us to retain the distinction between the way we tried to estimate an update that would take into account input prices and try and keep pace with inflation, on the one hand and Congressional action that was intended to entice people into underserved areas. It has a different motivation and a different reason. It doesn't make sense to commingle those and just say, it all adds up to about the same number, it must be okay, because they have different purposes.

MR. HACKBARTH: So what we want to avoid is implied endorsement of the distributive policy. We want to make it clear that we think the appropriate update is the 2.3 percent. That's the message, right? Then if we wish to look at the distributive issues later on we can do that as a separate matter when we've got more time and opportunity.

DR. MILLER: I'm really reluctant to do this with this many people in the room, and Kevin, if this is way off base -- I mean, part of the nervousness I had about thinking

through the distributional stuff in a short timeframe is I myself, and many other people, I think were carrying around the notion that these physician dollars were targeted to small areas and small groups of physicians. Yet if you look at some of the scoring, there's a fair amount of dollars that are traveling through some of these mechanisms. So exactly how far out they're going to reach is something of a question.

Now if I'm way off base here, Kevin, you need to correct this. But this is part of what we're starting to unpack. I walked into this legislation thinking there was a whole bunch that went to underserved areas. I think that's the general intention, but the definition of the area is at least not clear to me at this point. And like I said, there's a fair amount of dollars traveling through this.

DR. HAYES: One way to add to what Mark said is to think about the new bonus payments, the new 5 percent bonus payments. They apply to areas with the lowest physician to beneficiary ratios such that the cumulative beneficiary enrollment in all such areas that are eligible for this bonus equals 20 percent of Medicare enrollment. That's a pretty large percentage of the beneficiary population.

One observation we had at the staff level was that 25 percent of beneficiaries live in rural areas, so this is a pretty large -- now granted, not all of those beneficiaries stay in those places and receive care there, but it just gives you some idea of breadth of some of these provisions.

DR. STOWERS: On page 23 you got a little bit into the PLI -- and I don't mean to get off into this PLI thing altogether because it's -- but you talk about the projection of 4.7 percent, or 6.6 last year and then it went to 16.9. I only make the point that if we're talking access to beneficiaries, Oklahoma went up 44 percent last year and we got hit with 80 percent this year for the average physician in increased premiums. That's probably going to affect access more than the basic fee schedule in Medicare, especially in a lot of our specialties, neurosurgery and emergency medicine and that kind of thing.

I would like to see you develop this text box maybe a little bit more to show, maybe the word was sensitivity to which Medicare is going to respond to particular specific geographic areas and specialties to carry its part of this crisis that's happening around the

country.

In other words, if I'm a specialist providing care to Medicare beneficiaries, what percentage of that increased hit is going to be covered by Medicare in this formula, and in what timeframe is that going to be covered? In other words, is there some assurance, if I read this MedPAC report, that the Medicare fee schedule is going to respond to my problems? I think that plays a big role in whether I'm going to stay a participant as much as what the actual amount I'm getting paid for a particular procedure.

MS. BOCCUTI: I see what you're saying. What's in the text box explains that there is really two mechanisms for dealing with the PLI. You bring up the one that is more sensitive, which is the fee schedule. It's more sensitive to specialists and to geographic areas because its differential in that way. Whereas the MEI's capture of the PLI is not, so that's all over.

But I think the point that you're trying to make, and make sure I understand you correctly because you're talking about addressing this in the chapter, is to draw some conclusions about adequacy and access with relation to the PLI. I see what you're saying in that we didn't really

say that this may or may not to affect access and how. But we did show the example of a Detroit neurosurgeon who is in an area that has high PLI.

DR. STOWERS: I'm just trying to quantify it. One of our surgeons jumped from $20,000 a year two years ago to $85,000 in premiums and 50 percent of his practice is Medicare. Is his Medicare reimbursement going to increase that 50 percent in between to cover his --

MS. BOCCUTI: We'll try to make that clear.

DR. STOWERS: Do you see what I'm saying?

MS. BOCCUTI: Yes.

DR. STOWERS: It would be nice if that's explained in here, that the Medicare formula is going to take care of what's happening to him in that particular community in Oklahoma.

MS. BOCCUTI: Or How it does.

MR. HACKBARTH: Of course it won't address it for every individual physician and every circumstance.

DR. STOWERS: I understand that.

MR. HACKBARTH: But I do recall in the November materials there were some examples of the power of the interaction of the two factors, the MEI component plus the

specialty-specific geographic --

DR. STOWERS: We could go a little further maybe. Thank you.

MR. DURENBERGER: I really don't intend my comments to change any of the wording in the decision but I've just finished going all over the state of Minnesota and North Dakota because I'm chairing a governor's citizens forum and so forth and there's very little in here, if I took this around Minnesota with me, that would reflect the reality of what's going on in -- I mean, if I sat down with physicians there's very little in the nature of this presentation that would reflect the realities of what's going on in Minnesota today. I don't mean that as a criticism because I know we have a particular way of having to approach the updates.

But I hope between now and the next time we address this that we would spend a little bit more time talking about how the practice of medicine is changing in this country, about how the variation in practice actually leads to variation in the deployment of various kinds of doctors in a wide variety of communities. I'm sure Nick experiences this as we do across our part of the country.

If I asked people in Minnesota today, doctors in Minnesota today, what's the greatest problem with Medicare payment, they would say the disparity between the financial rewards for primary care and the financial rewards for specialty care, because of financial rewards for specialty care are driving subspecialty hospitals, ambulatory surgery, all that sort of thing, driving people out of general hospitals in rural as well as Twin Cities type areas into other parts of the country. I've told you this before, we now have 38 heart hospitals in two states, two relatively low populated states, Minnesota and Wisconsin and only three of them meet HEDIS requirements. That's the tip of the iceberg.

The point simply being that there's more to the payment formula than the annual update across the board. I really think that at some time we need to deal with that.

There are other issues like shortages. We have a lot of health profession shortages in our state. To the extent that it's ancillary health professionals you are loading more work on the primary care doc, whether it's nurses or whatever the case may be, dentist, a whole lot of other people.

There are specialty shortages that are really interesting that relate to what goes in and out of the education pipeline. There was a time I was told the other day, there was a time in the late '90s in which anesthesiologists in our state were making about -- to come to work for our hospital, were making about what nurse anesthetists were making, just over $100,000. The last anesthesiologist hired by a hospital in Minnesota got paid $400,000-some. It's a reflection on a marketplace.

I don't know that we're all that different from a lot of other places in America. I just think the markets are changing fairly substantially. There's nothing very static about them. All that means is that within the context of a broad-based adjustment for Part B there are a lot of other things going on that affect beneficiary access. So I'm merely saying that I think we owe it at some point to the professions out there to do not just the update but to try our best to describe how and why the payment formula plays some role in either facilitating positive practice changes or as a barrier to the kind of changes that ought to take place.

MR. HACKBARTH: I think a considerable piece of

the reform legislation changes in physician payment were directed at the geographic issues and the difficulty of attracting physicians to certain parts of the country. Now whether they did it right, went far enough or too far, again I don't have any opinion on that and I think that's a subject we can come back and look at. But that's certainly one of the pieces of commentary that --

MR. DURENBERGER: But to me that's the old command and control thing, as some of my more conservative friends -- in other words, we have no way of deciding -- the people that decide that are people like Nick Wolter, Roger Gilbertson who runs Merit Care, which is a huge organization up in Fargo. Those are the people that -- they have to g out and pay $400,000 for a subspecialist, or some other people, who may get paid a lot less in the Medicare program. But they're making those decisions today simply because it's important to put certain kinds of combination of primary and specialty services in certain communities.

In our neck of the woods, the nature of practice often addresses shortages better than doubling the payments to public health doctors or something like that. So I'm not arguing with the fact that there wasn't an effort to do

that. I'm just saying I think docs do a better job usually of doing that than does the reimbursement system.

MR. HACKBARTH: Bear with us for a second because I want to make sure that I'm understanding what you're saying. There are several factors that influence beneficiary access to physician services, which is ultimately our goal is. Only one of them is the update. In this conversation we're focused principally on the update factor.

A second is the geographic formulas for adjusting payments. We're not taking that up here, but again, that's something that we very well could delve into and offer some recommendations in that area.

A third is the specialty differentials that you alluded to at the outset. If I understood you correctly you're saying you still think that specialists are paid too much relative to primary care.

MR. DURENBERGER: I'm reflecting what others say.

MR. HACKBARTH: I think we've gone a considerable distance over the last decade in reducing those disparities. I'm agnostic on whether we've gone far enough or too far, but that is a variable that the program has played with

substantially over the last decade. So we've not ignored that one by any stretch.

DR. MILLER: Just so you know, this question and the question that we were talking about with Bob Berenson is the same type of question. And just so you know, the staff isn't dead in the water on this. Kevin has been doing some work with Bob Berenson and some of his colleagues. This work is complicated and takes time, but we do have a path to address some of these issues, correct, Kevin?

DR. HAYES: Yes.

DR. MILLER: The review of the impact of the fee schedule and how it's affected the mix of funds between primary care and specialty.

DR. HAYES: Yes.

MR. HACKBARTH: What we could do in the run-up to this discussion which will focus principally on the update, just make sure it's clear that we understand that there are other moving parts in this system that have a bottom-line effect on beneficiary access.

I think we've covered everything there. Anything else, Cristina, Kevin? All done? All right, thank you very much.

Next up is home health.

MS. CHENG: During my time with you I'd like to do four things. I'm going to take just a moment to review some of the information that we've already had concerning payment adequacy. I'm going to introduce some new information on beneficiary access to care, the volume of home health services, the quality of services, and the margins. Then I'll consider changes over the coming year. And finally, we'll have your discussion of the draft recommendation.

To review briefly, the conference report reduces the marketbasket update by 0.8 and restarts the rural add-on at 5 percent. Both changes will occur halfway through fiscal year 2004. In October we discussed some evidence that access for most beneficiaries to this benefit is good. Geographic access includes 99 percent of the beneficiaries. Ninety percent of the beneficiaries surveyed reported little or no problem in obtaining care.

We've also seen that the supply of agencies in terms of the number of Medicare-certified home health agencies has risen slightly since the implementation of the PPS. Good access and a rising supply of agencies both indicate that payment is at least adequate.

Because of continuing concern about access to care we have pursued this question further with two additional studies. In June we contracted with Chris Hogan of Direct Research to look at claims data and demographic information of the Medicare beneficiaries. We found that during the period of decline in home health from 1996 to 2001 the greatest declines occurred among users with the least well-defined needs for skilled care. That is, when we compared the diagnoses of users before and after the decline we found that users with markers of frailty and chronic conditions such as COPD or chronic heart failure had the greatest decline while those who could conceivably be restored or recover under home health care, such as strokes or hip injuries had smaller declines.

This change is consistent with the change in the focus of the benefit from the continuing care of chronic conditions to the recovery from illness or injury. We also found that users in the highest use states had greater declines.

In a separate study, Nancy Ray used a national survey of home health providers about the demographic and clinical characteristics of their patients. We found that

the older-old and the more functionally disabled used the benefit in greater proportions in 2000 than they did in 1996. Use by female beneficiaries as a proportion remained about the same.

In both of these studies there is no evidence that these vulnerable populations have been systematically excluded from this benefit over this period.

In the recent past volume has been particularly volatile in this benefit. Some of these changes in volume reflect differences in the volume of users, which rose from '92 to '96 and then fell during the IPS and the initial year of the current payment system. Other changes in volume reflect changes in the product that is home health, the number of visits per episode, the mix of visits by visit type, the typical length of stay for a beneficiary from the time that they were admitted to home health to the time they are discharged from home health.

In 2002 and the first half of 2003, rapid reductions in the number of visits per episode and the length of stay have slowed. Perhaps the current average of 18 visits per episode, which showed almost no decline over 2002 and the first half of 2003, will continue. The length

of stay in home health actually ticked upwards slightly between 2001 and 2002. That's another sign that the trend of shorter episodes with fewer visits may be ending.

The changes in the mix of visits have also continued, but at a much slower pace as we've seen therapy continue to become a slightly larger proportion of the total number of visits in terms of the mix of visit types. If payments were not adequate we would expect the decline in volume to continue. That would be consistent with the product change and the incentives of the PPS which is a capitated system. However, the steadying of these volumes suggests that payments perhaps are adequate.

To pursue this a little further, we analyzed a 5 percent sample of claims to count the number of unique beneficiaries annually using this benefit. The volume of users has fallen in the past according to the CMS trend that I've shown on the left hand here. From our analysis on the right hand, the number of users appears to have increased between 2001 and 2002. We will continue to monitor the volume of users. Based on the change from 2001 to 2002, the evidence suggests that payments are at least adequate to incent providers to take on some new beneficiaries.

Another piece of new information that we have regarding the adequacy of current payments is a measure of the quality of outcomes of care. This graph displays be pre- and post-PPS measure of quality for home health. This score was developed for MedPAC by Outcome Concept Systems. It summarizes clinical and functional improvements as well as adverse events for all the beneficiaries in the national OASIS database. We use the scores on the OASIS patient assessment at admission and then we compared them to the scores at discharge. Patients received a two for improvement, a one for stabilization, and a negative one for a decline, or for one of four sentinel or adverse events that occurred during their stay in home health.

As you can see, the median score from 1999 to 2002 is virtually the same. Now this is based on 100 percent of the OASIS assessment so it is a real difference, but you can see that the difference is smaller than the standard variation in 2002.

Since the quality has remained the same, that adds an important context to two important indicators in our framework. We can see that beneficiaries have had the same access to the services that they need before and after the

PPS because their outcomes have not declined. Also since quality has remained the same we can conclude that the decline in the cost per episode is a real increase in productivity rather than substituting an inferior product. We also looked at the severity of patients and we can also conclude that it's not a substitution of less severe patients for more severe patients because the severity of patients at the beginning of their care in these two years rose from 1999 to 2002.

The final new piece of new information that we have on payment adequacy are the margins. One of the issues that we had last year was a somewhat smaller sample of cost reports than we would have liked. This year we have some real improvements in our cost report data. I want to genuinely thank the folks at CMS who not only processed all these cost reports in a very timely manner at the same time that they were making a tricky transition from one type of database to another. We appreciate the efforts that they made to make this data available. As a result of their hard work we now have 3,500 cost reports, and that's substantially all of the annual cost reports for freestanding agencies with Medicare costs and payments

greater than zero.

This year we were able to use a full fiscal year sample of cost reports. They did not span the implementation of the PPS, and thus we've avoided a cost allocation problem. The cost reports that spanned the implementation date appear to have underreported their costs under the PPS compared to our newer, complete sample. This cost allocation did affect our sample last year but it will not have an impact on our future samples of cost reports. Because our latest data is also newer than it was last year, we were able to use a large sample of fiscal 2002 cost reports to measure the trends in cost between 2001 and 2002.

So using this new sample we have derived our estimate and projections of the Medicare freestanding home health agency margins. The aggregate projection for 2004 is 16.8. This number does reflect the provisions of the conference agreement.

We also had an opportunity to look at the margins by type of control of the agency. You see that voluntary, for-profit agencies had a lower margin than the private agencies, and government had a somewhat lower margin than that. We also compared the margins of urban and rural

agencies and this is by the location of the agency. The 2001 estimate includes the rural add-on that was in place at that time that was 10 percent for the entire year. The 2004 projected estimate includes an add-on of 5 percent that's in place for half a year.

As you can see, in 2004 the urban and rural margins moved somewhat closer together, and the rural is somewhat lower than the urban. However, we also looked at this in terms of the caseload of the agency and when you compare agencies with 100 percent urban caseload to agencies with 100 percent rural caseload, the rural caseload agencies are slightly higher again than the urban; the same relationship that they had in 2001.

In summary of this table, the aggregate margin of 17 percent would appear to be more than adequate payments for the Medicare costs.

Now I'll move to changes that we expect over the coming year. The marketbasket which measures changes in input prices is 3.1. However, evidence suggests for this sector that productivity and product change will offset the increase in prices. We base that on our observation that cost per episode fell 10 percent from 1999 to 2001 and they

continued to fall between 2001 and 2002. We have estimated for the purposes of our model that they will not rise over the coming year.

We also have evidence that scientific and technological advances will continue to proliferate. Some agencies have only made these investments and given their potential it seems likely that they will continue to diffuse throughout the sector.

The two most important scientific and technological advances that we have seen for this sector is the increased use of electronics in the home, such as bedside monitoring and diagnostics, and the use of negative pressure or hot wound therapy. Both of these therapies have evidence that show that they can enhance quality in studies from journals such as the Annals of Vascular Surgery and the Journal of Dermatology. It is also found that better monitoring can catch problems like weight change faster which should improve the outcomes for beneficiaries.

These technologies can increase prices in the long term, but those same studies generally found that they would improve productivity because they can decrease the number of visits necessary per episode to treat a wound or to monitor

a patient.

In our framework, evidence of upcoming scientific and technological advances could lead us to recommend an update that's slightly larger than otherwise. We do find that this sector has limited access to capital, but we also note that they've had several years of large, positive margins which ostensibly could have been used to make the advances in these scientific and technological advances.

Which brings us to the draft recommendation. Taking into account evidence that current payments are at least adequate or more than adequate, as well as evidence that payments will continue to be adequate over the coming year the following draft recommendation has been developed. That Congress should eliminate the update to payment rates for home health services for fiscal year 2005.

The spending implication would be to reduce spending compared to current law, and given our evidence we conclude that the beneficiary and provider implications would have no major implications for this sector.

At this time I'd like to get your discussion of the draft recommendation.

MR. HACKBARTH: I know Carol has a comment but

could I just ask a question, Sharon, about the preceding slide? The second bullet says productivity and product change will offset the increase in prices. Earlier you had made the point that one of the forms that much of the product change took early on was the reduced number of visits per episode. If I understood you correctly, that has leveled off now, so that aspect of product change may have run its course.

But you're still saying that notwithstanding the fact that fact that the visits per episode is flat that you think the productivity and product change will offset the increase in input prices? Am I understanding you correctly?

MS. CHENG: The change in the model that I made between this year and last year was that last year I used the evidence that I had that the product was changing and that costs were going down to actually project that costs would continue to go down. This year I see that the costs did go down between '01 and '02, and I don't see evidence that the product change is going the opposite direction so I've modeled that they will not increase but I have not modeled that they will continue to decrease. So I actually

have a cost change of zero.

MR. HACKBARTH: I'm not sure I follow.

DR. MILLER: For just one second let me try and clarify this. I'll take responsibility for this. We talked about what words to put in here. I think the point -- and make sure I get this right, Sharon -- is that we continue to observe a reduction in cost per episode. We didn't find the drop in the visits like we had previously so we weren't quite sure to attribute what this reduction in cost was to. So we were, what should we be saying here, and I think I said, just put productivity and product change since we don't know what was really driving the reduction in the cost. But we did continue to see -- I hope I'm getting all this right -- a drop in cost. We just didn't see the drop in visits like we had in previous years.

Then her last comment is, in order to be conservative we didn't assume that their costs declined in forecasting forward, we just assumed that they would be flat. Is that fair, Sharon?

MS. CHENG: Yes.

MS. RAPHAEL: I just want to enlarge the payment issue here and take it a little beyond just the question of

the payment update, because this is two years now since we've introduce the prospective payment system for this sector and I think we've seen effects on reductions in utilization. We've seen effects on the types of patients who are receiving the benefit. We've seen, I believe, very serious changes in payer mix. We've seen changes, I think, shift of site of care and effects on out-of-pocket costs for beneficiaries. Lastly, I think we've seen some effects on access.

First of all, I think that one of the areas that I'm very concerned about is if I see that it is advantageous to change your payer mix so that you have a higher Medicare percentage, pure Medicare percentage. Because for example, an organization like mine that has one-third of our patients who dually eligible, that group of patients in fact have much lower margins than those that are only Medicare beneficiaries. In fact the irony of it is that that group of patients have a lower case mix index. You can say, how can that be? And they use more services.

So the way that the OASIS and the whole categorization and scoring occurs is that you don't really get a different score for being somewhat dependent or

totally dependent, and it's not a good predictor of the use of paraprofessional services. So my average Medicare-only patient they have nine home health aide visits. For dually eligible they 23 home health aide visits, even though that category has a lower case mix index. So that that group is a much higher utilizing group. Whether it's because they are poorer, more likely to be disabled, less likely to have caregivers, I don't know all the reasons. I certainly have no clear information, I just have my own experience to draw from here.

But one of the concerns that I have is that I think -- and I just was speaking to one of the Wall Street analysts who had called me and he told that one of the companies in the last quarter had increased their Medicare share by 11 percent in one quarter. So that you can have a gravitation toward taking only Medicare beneficiaries and you can really impair organizations that take dually eligibles, because it is much less advantageous to take that segment of the Medicare population. I think that we have to really look at the implications of payment on access and future access for that particular group.

In addition to which, I just continue, and Sharon

knows I feel this way, not to agree with the conclusion that the focus of this benefit has changed, and that it what Congress intended. That we focus on people who have had hip fractures and that we don't focus on people who have cardiac conditions, congestive heart failure or pulmonary disease. The norm for people over 80 is they have chronic conditions with acute exacerbations. It's not just the norm that they have an acute injury or an acute illness. The norm is quite the contrary. This benefit should be for people who have chronic conditions with acute exacerbations. I don't think that we're looking to change that.

When we say that we comfort ourselves that the decline has been for those who have a less clear and defined need for home health care, that is those who have pulmonary disease and congestive heart failure, I don't take great comfort in that because that's a group as much in need as the group that's had a fall. So I'm very concerned about drawing that sweeping conclusion which we draw.

We look at utilization in 2002 and we also draw comfort, all is well with the world, because the same number of people are utilizing the benefit in 2002 as did in 1992. But guess what, I think there were 37 million Medicare

beneficiaries in 1992 and now there are 40 million and the proportion of those over 85 has increased. So I don't draw great comfort from that either. So I really think we need to spend some time taking a look at these issues.

Now I know you quote this one study, the National Home Care and Hospice Organization study, but I believe that the National Institutes of Health Statistics suspended that study because they thought that it wasn't a good survey and they're really trying to recast that study. If you look at the Health Affairs article in September and October by McCall and Murtaugh, they say that basically the probability of getting home health care for the 85 and over has in fact declined between '99 and 2001.

So I think there are some very important issues there that we need to pay attention to. I'm not even talking about uncompensated care, because I, for example, this year have seen 8,000 cases that have no insurance. And I don't get any DSH payment for seeing uncompensated care cases in the current system. So I'm not even raising that because I know DSH has another set of issues attendant to it.

But I do think we have to ask ourselves what kind

of agencies do we want to ensure are there in the future so that we have broad access for all parts of the population here, and that we don't have incentives in the system that lead you to go only in one direction.

In the June report we had made a statement that we thought there was some shift of site of care to nursing homes and some substitution for home health care. We also have had a principle that we really believe that any substitution should be on clinical grounds not on payment grounds. I think we need to go back and look at that, because I don't know why that substitution is happening and why nursing homes have grown in terms of the number of patients and home health care as a sector has declined. So I just think that's another important area.

I have issues around productivity but it's probably not too much different from my other colleagues who have expressed it, but I know we're like a tertiary care center in home care. You talk about the vacuum pressure and heat in wounds. Less than 3 percent of our wound care patients are getting that, and we have the most broadly disseminated technology. You can use it for surgical wounds, you can't use it for vascular wounds. You have to

have a caregiver to do the dressings.

Sharon, you attended this big colloquium we had of all the agencies who are involved in a big quality initiative, and it's infinitesimal how many of them actually have computerized. It's an aspiration. It's not an actuality.

So I just think that I don't see this productivity gain that we're purporting here. I see it in the literature. I don't see it yet in practice.

DR. WAKEFIELD: A couple of comments -- and actually I think you touched on it, Carol. I was wondering about where -- and maybe we did address this somehow in the June report because you seem to allude to it -- where the users with least well-defined needs are described, those with chronic care problems, CHF, et cetera, where then now are they getting their care? Are they getting their care? Do we have any sense of that? If the benefit has shifted in terms of what's being covered then what's happening to that patient population in terms of that particular care need?

I'd only say just as an anecdote, there was an article that appeared in our local newspaper just within the last week about a Medicare beneficiary who was being seen at

home for congestive heart and they were using a phone and access long distance using telemedicine technology, and the numbers of hospitalizations of that particular beneficiary -- now that's an anecdote of one -- but it had dropped significantly as that patient was being followed at home, and in fact long distance at home than the previous year. So it was touting the benefits of telemedicine, but also the point being made that that was a patient that was not using inpatient services to the extent that he had in the previous year.

So I'm wondering about that. Where are those patients, those Medicare beneficiaries getting their services and how are those being paid for? Just as a question. Perhaps you can't answer it.

Then secondly, we've got a chart that talks about Medicare freestanding home health agency margins but I don't know what's happening with hospital-based home health agencies. I don't know what the distribution of hospital-based home health agencies rural versus urban. I don't know what they are but my guess is that we tend to see a fair amount of them in rural areas -- at least that's what I hear from my rural hospitals -- that when they don't have

anything else they've got to -- in order to ensure that there's some provider of home health agencies it falls to the hospital as the last person or entity standing in the community to provide that service.

So could you give us a breakdown of what might be happening with hospital versus freestanding on home health, just as we've seen that with SNF, for example, the hospital versus freestanding SNFs? I guess that was probably my second and last point, because it looks like our recommendation applies to all home health services in both of those categories but I'm only seeing margin data on one.

MS. CHENG: That was a decision that we actually made in looking at the cost reports. We do find that the freestanding home health agencies were 68 percent of all agencies in the program, 70 percent of all Medicare payments, and 67 percent of all episodes. So they are the majority of the providers in the program.

When we looked at the distribution we didn't see substantial differences in the distribution of freestanding and hospital. I can give you more detailed breakdowns on exactly how they pair up. But we felt that the cost allocation issues that are common to all of the hospital-

based units seemed especially to hit home health agencies that are hospital-based. So we felt like the biggest difference between hospital-based and freestanding was the cost allocation that the hospitals made more than a real difference in their performance. So is not quite apples to oranges which is why we don't lump them together.

DR. WAKEFIELD: We always add the wraparound language about cost shifting within hospitals. But if you're talking about the similarities with this, to say inpatient versus outpatient margins, if that's you're saying, but we also have at least historically always looked at those and then inserted that caveat. Are you saying these numbers would be so murky and so misleading that it's not worth even taking a look at what those margins are for the inpatient --

DR. MILLER: I think the answer to that is that we're going to move into the hospital section next, but at this point we don't have -- we'll have for the January meeting hopefully, we have an aggregate margin for the hospitals. We're not going to be able at this point to detail the allocation within hospitals and even break down hospital types at this point. We just aren't that far in

the analysis. You're point is taken but we're not going to be able to present it at this meeting.

DR. REISCHAUER: Just on that point, do we have any information about the closing of hospital-based home health agencies? Because if they're growing or they aren't shrinking, then one might conclude that it's not a bad line of business to be in.

MS. CHENG: There's a table in your materials on page 7 that gives you a breakdown of the agencies by type. In '98, freestanding were 72 percent of the agencies, facility-based were 28 percent. And if you read that across it's 70/30 and then it/s 72/28 again in 2002. So as a proportion of the sector it stayed essentially the same.

MS. BURKE: I don't mean to be repetitive but I am as concerned as Mary about want this suggests about our capacity to evaluate the impact of a no update for the hospital-based facilities as compared to the freestandings. I also very much agree with Carol, I think there are a whole series of issues about home care. I agree with Carol, I don't think that we intended that the nature of the service change, or the nature of the patient that we serve change to the exclusion of people that we had cared for traditionally.

Our capacity to care for people at home has clearly changed. Our capacity to introduce technology has allowed us to care for people that years ago when I was in practice we couldn't have cared for in a unit.

Having said that, I don't think it was to the exclusion of the chronic patient. I worry about a presumption that in fact, all things being equal, that there is no increase needed because of the margins we see that are based on the presumption that we're changing the nature of the patient.

I also am sensitive to Mark's point, which is that we can't easily examine the hospital and how a hospital allocates costs. But I think to suggest that in the absence of that information we presume that this kind of an update makes sense for hospital-based units who may face very different kinds of circumstances is risky, and it concerns me. Yes, we have remained relatively stable but that occurred after a period of time where there was a shift away from hospital-based to freestanding. All the changes in terms of the way we financed home care that occurred in the '80s and '90s led to a dramatic increase in the number overall and a shift towards freestanding.

But I am very concerned that we look carefully at hospital-based as an individual set of institutions rather than presume that this answer is the right answer for that segment, because I don't think we really do know what the impact will be, nor the nature of that in terms of the kinds of patients that they serve.

DR. STOWERS: I just want to echo a little bit about what Carol was talking about. On page 6 you mentioned that we maybe needed to look into the fact that there was a decrease in home health aide visits, and then in the chart on page 10 we see that it dropped from 50 percent of the visits down to 23 percent of the visits. In our practice, I just want to try to describe what that's really interpreted to.

When we have chronically ill, 80-year-old patient that's had an acute episode of congestive heart failure and they become debilitated from it, it used to be that five to six days a week they got a bath, and someone came in and changed the sheets and took care of the home. Now in we're really lucky I can get someone into the house to do that twice a week since the PPS has come into effect. So that's the state of the health or cleanliness of that patient at

this point because those aides, they're just not there any more. That's if we can get them at all. I would say half of our agencies don't have aides at all anymore. So that has fallen on the families, if they have a family to do that, and most family members are not either mentally or physically prepared to come into the home and do that kind of care and lifting and that sort of thing.

So when that structure breaks down, what's happening is they're going into the nursing home earlier, not because we don't have a great physical therapist or great nurses or that kind of thing, but they are diverting off because the patient is left in an unclean situation and an unhealthy situation with a poor diet, no one to cook their meals for them. This may only need to be done for a two or three or four-month period until they can get back on their feet out of this acute episode that's happened in their chronic medical illness because home health is now geared up for a post-fracture or post-hip surgery or whatever that we weren't geared up for in the mid-'90s.

So I really think we need to look further at this structure of care because we're concentrating on high skilled nursing care and physical therapy and all that, but

what keeps these people at home is often the lower-skilled individual that just give them the basic of everyday care that they need, which we had before. It's been a drastic change in the type of care of these patients in their homes since -- just in the last two or three years. It's something to see on a daily basis and their quality of life. So I just wanted to make that statement.

DR. REISCHAUER: I have a lot of sympathy for Carol's plight, but I don't see that it has much relevance to the update issue. What we seem to be saying is, there appear to be quite healthy margins in every component of this industry that we can ascertain now when we slice it and dice it by urban and rural, and voluntary and private, and so on. We don't have the hospital cut yet but maybe we'll have it in January. So in the aggregate there's enough money but the payment system within that aggregate is biased in favor of the high skill type of care and what we need to do is redress that imbalance, and there's plenty of money to do it.

MS. RAPHAEL: Plenty of money to do it? I don't think there's plenty of money to do it, because if you have a high proportion of Medicaid, which I didn't even raise for

the reason of trying to be consistent here. But if you have a high proportion of Medicaid and you have a high proportion of dually eligible, either you're in a rural area, inner-city, wherever, there isn't plenty of money. There's only plenty of money if you change the mix of your patients, and I think that's more important than utilization per patient.

DR. REISCHAUER: I'm not talking about plenty of money within your agency. What I'm saying is within the system. So those agencies that are doing a whole lot of the high-end type of home care would receive less and it would be shifted to those of you who didn't. But a 16 percent margin strikes me enough to walk around the neighborhood with.

MR. HACKBARTH: The other side of that coin is that the update factor is a crude tool to deal with the problems that you're talking about because it would increase payments to agencies that have carved out a very healthy, profitable niche. Sort of the blunderbuss approach to fixing the problem. But if I understand your point correctly, this is a distributive question. This is a case mix question, are we fairly allocating the dollars we've got as opposed to is there enough money in the system in the

aggregate?

MS. BURKE: I'm not sure it's just case mix, Glenn. I think that could well be. Bob's point is right, there's probably enough money in the system. There is an aspect of it that is case mix in terms of what the distribution of patients look like. But I do worry that is still doesn't really answer, and perhaps we will be able to, the nature of the hospital issue and the freestanding issue, which is -- I don't know what that looks like. It may have the same kind of margins, but I don't know that, and I don't want to presume that one location is in fact the same as the other. In fact it may be a case mix issue, it may be a geographic issue, but I don't know that without seeing what the a hospitals look like.

MR. HACKBARTH: On the face of it I would have thought that the allocation issues between inpatient hospital and home health may be somewhat less difficult than a service like hospital-based SNF, because you're talking about a business that is direct labor costs. They're operating, by definition, outside the hospital, not sharing facilities and the like, so the allocation, the accounting issues presumably would be less than for some other

services.

MR. MULLER: If I can just, based on the discussion we're having here about whether with the perspective payment now we have some incentives, whether it's Ray's anecdote of the frequency of visits and so forth that causes people to flip back into institutional settings. Maybe you can refresh our memory as to the average cost of home care per year and do some sensitivity analysis of if X percent of these patients flip back into an institutional setting, whether it's hospital or a nursing home and so forth, what does that cost us in terms of the institutional costs versus what we're saving in the home care.

I think just having some kind of sensitivity chart in there, for example, let's say if a hospitalization is five times as much per year as a home care visit, then -- as Glenn said earlier, you shouldn't do your arithmetic in public too many times -- but basically if it costs you five times as much when they flip, then if 20 percent of the patients, to use that loose term, flip over from home care into an institutional setting, what kind of savings are we securing in terms of the program? Just do that kind of comparison, that would help.

I think, to go to Sheila's point briefly and Carol's as well, we've said a number of times and I raised the point earlier around physician payments, we try to just look at the margins inside the Medicare program and not look elsewhere. But obviously if you have a lot of Medicaid then in fact, like in Carol's caseload and perhaps some of the rural caseloads, you have less margin to be able to do the kind of things, to have the kind of amplification of services that when you run a more -- when you run a home care program that's largely Medicare that has these kind of margins. So what in fact may happen is you tend to skimp more because you're cross-subsidizing the Medicaid, and therefore that may have an effect on the Medicare program if you're skimping on some of these services that cause people to get back into the institutional setting.

So again I fully understand why we don't want to get into saying we should use the Medicare program to cross-subsidize other programs, but if it has the effect of some skimping in the program because of cross-subsidy in Medicaid that then costs money to Medicare, if that isn't too long a sequence of argument, that's something I think we should be at least attentive to as to what the cost trade-offs are.

MR. HACKBARTH: Sharon, can we bring some data to bear on the issue of patients be readmitted to hospital or SNFs from home health? Some trend data, what is happening. That might be a metric worth tracking.

MS. BURKE: Glenn, could I just add to that? It would also be interesting, and I'm not sure whether we do know this, but what proportion of patients receiving home care are who are duals as compared to the general population. Is there a disproportionate number? Because that would also help us fully understand Carol's point, if in fact the number is greater than the number you find in the general population or against -- they tend to be high utilizers anyway. They tend to be more costly as a general matter. But I wonder if there's a disproportionate impact on home care. I don't know that there is but it would be interesting to know if there are any kind of data that tells us who it is that's using the service, which would give us some sense -- the case mix would pick up a little bit of that but not entirely.

DR. REISCHAUER: But the real question is, how has that changed over time?

MS. BURKE: True, absolutely.

DR. REISCHAUER: Which is what you want to know.

MR. SMITH: Building on Ralph's point, it would also be useful it seems to me, in going back to Carol a year ago, is what is the admission rate of the folks who are no longer receiving home care at all? That population, Sharon, that you described as the users with least well-defined needs, people with chronic multiple needs but who don't have something which fits more neatly into the way the PPS affects who ends up in home care in the first place. The problem may even be bigger, Ralph, than I think you were suggesting.

The other question, I think we have changed the benefit. We've changed it, in fact even if we didn't intend to, Sheila. Technology has changed the benefit a little but the PPS changed the benefit because it created a different set of incentives for providers. I do think the burden of a lot of this conversation is not whether or not Congress intended to do something stupid but whether or not Congress did something that has had a set of consequences which we didn't intend. We've come back to this point in this conversation now for three years in a row. It seems to me, Mark, that it is useful to try to figure out how to get a

handle on that.

The question -- it's not the precise way that we ought to frame it, but the question is, is there a benefit out there which used to be provided, maybe profligately and unwisely but in some cases usefully, which is not now being provided? And what are the consequences of that? What are the health care consequences? What are the admission consequences? What are the bounce back consequences to the Medicare program? All of those questions lurk in the background of this discussion and we've never made any real progress at getting at them. I'd like to see if we could try somewhat systematically.

MS. DePARLE: In response to your question, I think I remember that the Inspector General at HHS and perhaps even the GAO looked at, or tried to look at the question of readmissions among people who had been in home health or were no longer able to access home health. This was part of the immediate response to the decline in the number of agencies in some parts of the country after the BBA and the interim payment system. I don't remember the results of that but I think there may be some data at least from that period.

But in response to David and to some of the other discussion we've had today, certainly I think the data that we've seen and that we looked at last year reflects a more significant decline than most people thought would occur in utilization of home health as a result of the policy changes that were implemented in the BBA. But I think we need to remember that there was in fact a concern that the benefit was being overutilized and wrongly utilized and a number of the policy changes that were made were designed to address that, and to make some changes in the beneficiaries who received the benefit. Some of that was the concern about the homebound requirement, and I don't think that's even yet been resolved.

But beyond that there was a concern about the policy that was implemented to require the physician to certify was partly designed to get at this view, and I think in some cases it was well-founded, that the agencies were going out to beneficiaries' homes and saying, would you like home care and then sending the order over to the doc and saying, sign this, the person wants it. Also the split between Part A and Part B, moving home care around, some of that was a gimmick to get it off the Part A trust fund.

There was, perhaps after the fact but at least there was a policy rationale as well that you were dividing it up between those beneficiaries who were using it after a hospitalization and those who were the others. In either case, I think this requirement of the physicians -- and the clinicians here should answer this -- I think that had a dramatic impact on the number of beneficiaries and maybe even the type of beneficiaries who were getting it and the kind of care they got.

Now all of this may now seem shortsighted and not cost-effective and there may be people falling through the cracks that we think should be getting home care, but I think we need to remember that however ill thought out it now seems, at the time I think people thought it was well-intentioned.

MR. HACKBARTH: I think that the core issue here is the ill-defined nature of what we're trying to buy. I think there have been historically different points of view within the Congress about what the benefit should be and whether in fact we were trying to accomplish a change or not by implementing a new payment system. I think there's some fundamental disagreement that's never been sorted out.

But you take the combination of the new payment system with fairly strong incentives to economize with an ill-defined product and it's pretty predictable I think that you're going to get changes in the product, because the economic incentives will be so strong that they will overwhelm the underlying patterns. Whereas if you're dealing with an area of medicine where there are very clearly defined standards as to what you need to provide, the economic incentives may have a very different, much more limited impact.

So I think one of our core issues -- and we've made this observation as I recall, in past reports -- is that we've got a vague notion and not uniform consensus about what it is we're trying to buy here.

Then on top of that we have the issues that Bob and Carol alluded to. Once you accepted that we're going to have a PPS system, a prospective payment system, are we fairly allocating the dollars we've got for different types of patients and what are the consequences of failure to do so? Then finally, of course, we have our standard issue about the update factor, is enough money in the system?

So we're in a position where we're focusing on the

update factor, which is in some ways the little tail on this great big dog. The policy question that that ultimately raises is to what extent are we going to help these problems that we've been cataloging by pumping more money into the system? I'll leave it at that. In some cases the money might get to providers who will do good things with it and begin to address some of the problems we've identified. But I think it's safe to say that a high percentage of the dollars will not go there and will go just to the bottom line of people who are providing a different sort of product. I think that's the dilemma that we face.

We're not going to resolve the longer-term issues obviously in the next month, but I think we ought to use this report as an opportunity to again lay out that there's a lot more going on here that needs to be examined than just the update factor and the aggregate amount of money in the pool. I'll leave it at that.

DR. STOWERS: I just think we'd be remiss, even if we don't give an update, to go forward to Congress and not talk about the maldistribution of dollars within this pool. I know we did it before, but we have one set of beneficiaries which it's very lucrative to take care and

another set of beneficiaries that it's very difficult to get care for. It just seems like to me that ought to be brought to their attention again that that needs to be addressed. For us just to say, things are great in the industry, there's no need for an update, I just would hate to send that message to Congress.

MR. HACKBARTH: Refresh my recollection, we certainly have anecdotal information about that. I don't know if we've got actual systematic data on which types of patients are getting poorly served or not getting adequate access.

MS. CHENG: I've tried to put together a little list here. I think realistically between now and January we could -- we do have the OASIS on hand with our contractor at OCS. We could ask them to look at 1999. They have 2000 and 2002. We could ask what kind of conditions were the patients admitted trying to improve in those years, in terms of has there been a change in the number of patients with wounds that needed care over that time? Was there a change in the number of patients who needed functional improvement that had some kind of functional limitation? We could get a trend of that over time to take a look at this question of

how have the needs of the patients been changing.

We could use OASIS. I don't think we can really get at a good hospital readmit rate, but what we could do is look at ER use and unplanned hospitalizations during the episode. We could look at those three years and see if that trend has changed over time to get a sense of the ER and the hospital use of this population.

One of the things that I brought a couple of months ago was based on the CAHPS fee-for-service survey. We looked at the difference between the proportion of beneficiaries who indicated they sought some kind of home care and our estimate of the number of beneficiaries who got some kind of home health care. In 2000 we found that 7.7 percent of beneficiaries sought some kind of home health care and 7.5 percent did receive it. We could pull that trend forward, I think, with the data we've got on hand to look in 2001 and 2002 to see if the difference between seekers and obtainers has changed.

MS. RAPHAEL: In your data here, in that survey you had 25 percent of the people had some problem or great problem in accessing care, and the 12 percent that had a significant -- you thought the 12 percent that had a large

problem you thought was statistically significant actually. So you have one out of four that had some problem or a great problem, and I'd like to understand that better.

MS. CHENG: Okay.

MS. DePARLE: Also when you say sought home health care, 7.7 percent, does that mean they had a doctor's order to get home health care?

MS. CHENG: The question was worded, did you feel or did a physician advise you to seek home care over the past year.

DR. WAKEFIELD: If you can, is could you also take a look at whether or not you could give us some sense of the distribution of hospital-based home health agencies by urban versus rural? You said that you think that they're pretty much the same distribution.

MS. CHENG: Yes, that was another item on my list. I'll see what I can bring you back of the hospital-based margins. We haven't dealt directly with the caregiver issue. I don't think I can bring too much data to bear on the question. If you're interested in maybe a discussion of the caregiver and how that's accounted for or not accounted for in the PPS payment system I could bring that back as

well.

DR. STOWERS: Could you give us the different like income or profit margin or whatever for different types of patients?

MS. CHENG: For different types of patients?

DR. STOWERS: Like rehab after a total hip that's gone home versus an acute episode of congestive heart failure, that gets physical therapy and all of the rehab, what that payment would be.

DR. MILLER: I think we want to be careful about saying whether we can do that. Even if we have the cost and payment ratios here it's a question of allocation. I think the answer to your question is we can look and see what we can do. I just don't know whether we're going to be able to tell you for this HHRG or whatever, this is the profit margin.

MS. CHENG: I was going to be more cautious than you're being. I'm not sure we could pull that off.

DR. REISCHAUER: I'd be very careful about promising anything definitive on hospital admission or readmission rates simply because you can't just look at the folks who have the home health care. What you want to look

at is everybody with this condition and what difference home health makes. Then you have to control for the people who don't have home health for that condition but have the functional equivalent of a family that is doing some of this themselves. As you know, it's horrendously complex and I don't want some of the other commissioners to get an expectation that you could actually come up with something here and interpret it in the right direction.

Carol was looking at Table 1 and thinking that the glass was half empty, and I was looking at it and thinking it was half full and was going to say that we have to be very delicate in how we describe the situation if the theme of the first few pages here which is that supply seems to be adequate. Things are okay. Those who want it seem on the most part to get it. We have to draw on Glenn's remarks which is the nebulous nature of this service. Many people maybe don't know what it is that they could benefit from, especially when you go from a change of the system like we had in 1996 to what we have now. The people are different, their expectations aren't to get all of this so they don't look for it and they aren't unhappy. But they could benefit maybe.

MR. HACKBARTH: Thank you, Sharon. We need to move ahead now. Next up is hospitals.

MR. ASHBY: In this session we are going to use our usual two-step process to develop update recommendations for hospital inpatient and outpatient services for fiscal year '05. But before I begin I wanted to take just a brief moment to acknowledge that while you're going to hear from Chantal and David and I on this project we actually had several other people that contributed substantially here. Tim Greene took the analytical lead on a very complex modeling effort, Craig Lisk brought us the margins we're going to look at, Jeff Stensland did a very useful disaggregation of cost growth, Julian Pettengill helped throughout, as he always does. We pulled in our post-acute team to look at hospital-based services. We pulled in Dan Zabinski to look at per-capita analysis. It was a cast of thousands and we appreciate the efforts of all of them.

Now back to our previously scheduled slide. We considered six factors in assessing payment adequacy, the same save factors that we looked at in the other sectors. We will proceed through them one by one in advance of our draft recommendations.

Beginning with beneficiaries' access to care, we examined two indicators, change in number of providers and the per-capita service use of beneficiaries.

We found no indication that access to care has deteriorated. The chart that we have here shows the number of hospitals participating in Medicare. If you'd look first at the white bars, or yellow on the screen, you see that 636 hospitals converted or opened as critical access hospitals through 2002. Actually that number through October of this year has risen to 835. Certainly that trend has done a great deal to stabilize access to care in rural areas. Then with the dark bars on the left we see that number of hospitals ceasing participation other than through conversion to CAH has dropped each year since 1999, and as of 2002 you'll notice that the number closing is actually equaled by the number opening.

Actually a moment first before we move to volume. Our analysis of per-capita service use in 1999 and 2000 -- unfortunately 2000 is the latest that we have -- shows that overall service usage is holding steady and that rural beneficiaries continue to use services at roughly the same rate as urban beneficiaries.

For volume growth we examined change in the number of discharges and change in length of stay. A large drop in volume might indicate that payments are inadequate, but in fact we found that volume continues to increase. In the first chart here we see that although discharge growth dropped slightly in 2002, the annual rate is still about 3 percent for Medicare and about 2 percent across all payers. The next chart shows the change in length of stay. You can see that the decline in length of stay has slowed until in 2003 length of stay for both Medicare and all payers declined by only 3/10ths of a percent, and that is the smallest decline that we've seen since the late 1980s.

We have quality of care followed by access to capital next and I wanted to turn the mic over to David for those two.

MR. GLASS: Quality of care we see some mixed results. We looked at some indicators developed by AHRQ and that we applied to the Medicare population. From 1995 to 2002 we looked at an in-hospital mortality rates, and for all eight of the indicators we looked at the rates analyzed went down. If we looked at 30-day post-admission mortality rates there was also improvement in six of the indicators.

Two of them moved up slightly.

Now what we did see was some deterioration in rates of patients adverse events, or these are called the patient safety indicators. We looked at 13 of those and nine of those 13 rates of adverse events went up over the period from 1995 to 2002. We'll discuss those findings in detail tomorrow.

By another measure, the CMS process measures showed improvement. CMS, through its quality improvement organizations, tracked 22 process indicators and there was improvement in 20 of the 22 for the period 1989-'99 to 2000-2001. You have to use two years of data for those because they're taken from medical records based measures. So quality of care is somewhat mixed.

Access to capital continues adequate. As the slide shows, spending construction is strong, more expansion planned, 80 percent of the non-profits are planning on expanding, debt issuance is increasing. Access varies by financial condition. Poorer performing hospitals are going to face more of a challenge, yet they still seem to be able to obtain capital, though they may have to pay more for it. There has also been use of some less traditional financing

such as selling physician office buildings and things like that to raise capital.

We'd also like to note that hospitals in systems, which are over half of the hospitals, have better access to capital than the stand-alone hospitals in general. So access to capital seems to be good.

MR. ASHBY: Turning to the appropriateness of our cost base, we found unusually high cost growth in both 2001 and 2002. We'll talk in a minute about some of the possible reasons for that high cost growth, but the bottom line is that we find no basis for concluding whether the growth was unnecessarily high, but this obviously is something that we're going to want to watch closely over the next year.

Our chart here shows that the rate of growth in cost per discharge has growth rather dramatically from 0.1 percent in 1997, and that was at the period of time when length of stay was falling rapidly, to 6.6 percent in 2001. Again that's a level that we haven't seen since the 1980s. For 2002, our preliminary value, based on 60 percent reporting, is even higher; 8.1 percent increase in cost per case. But for the 40 percent of late reporters that are yet to come in for 2002 we may have somewhat slower cost growth.

We'll talk about the reasons for that in just a moment.

To better understand these large cost increases we disaggregated the extra increment of cost growth in 2001-2002 relative to the year. We found that three factors, labor costs, malpractice costs, and capital costs were responsible for essentially all of the additional growth. Those three factors are shown in their order of importance here.

Starting with growth in labor costs, this was a key factor in both 2001 and 2002. Again, in the order of importance, that is attributable to greater growth in number of employees, greater growth in wages and benefits, and increased use of contract labor. Independent analysis by Peter Burhouse and others strongly suggest that much of the increase in employees, employees and contract labor actually, can be linked specifically to nurses.

They found, using the current population survey, that the number of FTE RNs employed by hospitals increase 7 percent in 2002 alone. The way that we define time periods, that 7 percent actually affects both our 2001 and our 2002 data. Burhouse also suggests that the crisis in nurse employment may already be ebbing, at least temporarily.

There are long-term structural factors but for the short term the problem seems to be ebbing.

I would also note that benefits increased even faster than wages, and that maybe due, at least in part, to hospitals being required to add funds to their retirement reserves as the value of their stock holdings fell. But with the stock market improving that should become less of a factor. Then also hospitals, like a lot of other organizations, have seen their employee benefit costs, health benefit costs affected by double-digit premium increases. Wouldn't want to hazard a guess on how long that phenomenon will go on but it was relevant here.

Malpractice costs. These costs increased a startling 35 percent in 2002, although malpractice is actually a very small share of hospital costs. But malpractice premiums are cyclical and we would not expect that level of increase to continue.

Capital costs. These also surged primarily in 2002. It's obviously linked to the renovation and construction boom that David talked about a moment ago. Whether all of the investment that we've been seeing is really necessary is an open question. It's something we

really haven't attempted to analyze, but it certainly is a relevant question. We would also point out that capital payments are made prospectively, like operating payments. They are made at a steady rate, so we would really expect the profit margin on capital payments to be somewhat lower at the front end of the capital cycle, and we would correspondingly see higher capital profits years down the line.

Some have suggested that the higher cost growth, particularly the higher labor costs, are essentially making up for the extreme cost pressure the hospitals were under in the last half of the 1990s. Certainly we can cite the fact that smaller length of stay declines have been a factor.

But on the other hand, others have suggested that the willingness of private insurers to grant much larger payment increases in the only 2000's may have fueled excessive cost growth. Yet another possibility is that the measured growth in inpatient cost per case -- we're essentially talking about inpatient here -- may be artificially inflated in recent years by hospitals halting their past practice of allocating as much cost as they could to the outpatient and post-acute care sectors in the cost

report since with PPS in those sectors there's really no longer any incentive to do so. We don't have any way at the moment of confirming how big a factor that might be.

Considering all of these factors, we find it quite difficult to determine the appropriateness of cost growth that's more than twice the increase in the hospital marketbasket, or to determine how quickly the industry can return to a more normal pattern of cost growth. But one indication that the unusually high cost growth may already be abating is provided by hospital wage and benefit data from the Bureau of Labor Statistics. Percentages you see in the graph here are four-quarter averages ending in the particular quarter noted. The peak increases of about 5.5 percent midway through 2002 had dropped to almost 4 percent by the end of fiscal 2003. That's when our actual measurement leaves off. The projection is that it will decline somewhat more through 2004.

Turning to our margins, this graph shows the trend in the overall Medicare margin, which we use to assess payment adequacy, and also the Medicare inpatient margin which provides the only available tool that we have to document the upward trend in margins during the 1990s. In

2001, the overall Medicare margin fell by 8/10ths of a point to 4.3 percent. The inpatient margin dropped a bit more, but that decline was offset by increases in the outpatient and hospital-based home health sectors.

The next slide shows our estimate of the overall Medicare margin for 2002 and our projection to 2004. The 2002 value of 3.2 percent shows a drop of about one point from 2001, obviously reflecting the high rate of inpatient cost growth that we have been discussing here. Our projection accounts for a number of policy changes that occurred between 2002 and 2004, and then also a number of policy changes that the conference agreement has scheduled to go into effect in 2004 or 2005.

So the 2.8 percent figure that we see here represents what the margin would have been, what we think it would be in 2004 if 2005 policy had been in effect. I really need to emphasize though that our projection is preliminary. This has been a rather difficult analysis. We have modeled the effect of 23 different policy changes in coming up with this one number, and that's not even counting updates which are essentially a gimme in the modeling world. So we have a bit of refinement yet to go.

But we will have a final number in January. We don't anticipate that the final number will be much different than what we're looking at here. Then we're also planning to present result of this analysis by hospital group. That will bring some interesting results we think. Among other things, we expect this to document a substantial narrowing of the margins between urban and rural hospitals. In fact we may even be reporting that the aggregate rural margin may exceed the aggregate urban margin when all these provisions are in effect.

Turning to first our inpatient update recommendation, and that will be followed by the update for outpatient. A little bit of context first. The current law increase is marketbasket even, with now a 4/10ths of a percent reduction for any hospital that does not first quality to CMS. CBO reports spending for the inpatient sector in 2003 of $94.5 billion.

Four primary factors govern our draft update recommendation. First is that we conclude that payments are adequate through fiscal year 2004. Although our 2.8 percent current margin is about a point lower than we've reported out the last couple of years, the other factors that we

looked at in our update framework don't provide any evidence of inadequate payments. Also, the conference agreement has removed the budget neutrality constraint from our inpatient new technology pass-through payments, and also has liberalized the criteria for technologies to qualify for the pass-through.

Then our second factor is the projected marketbasket increase. That is 3.2 percent. Third, we have our productivity factor of 0.9 percent. Lastly, we have our allowance for cost-increasing technologies of 0.5 percent. We'd like to note here that in future years we may find it appropriate to eliminate this technology allowance if spending for the new tech pass-through payments increases substantially. But we really don't know how that's going to play out. It depends somewhat on how CMS administers the conference agreement provision which has several little details to it, and also the number and the type of applications that come through. So we felt that for this year it's appropriate to leave the technology allowance in place while we monitor the implementation of the new provision in the coming year.

So marketbasket less 0.9 percent plus 0.5 percent

produces an update of marketbasket minus 0.4 percent as reflected in our draft recommendation statement here. However, one last point, and that is that we can't be sure about cost growth even for the remainder of the current fiscal year -- we're only two months into fiscal year -- for next year, as we've been talking about here. But the recommendation is for only one year, so we'll have an opportunity to revisit this in another year, and in the meantime to monitor the pattern of cost increases as well as the implementation of this substantial number of complex provisions that will go in from the conference agreement in the next year.

This recommendation would increase spending less than under current law, and given our analysis of the factors today we don't expect any major implications for beneficiaries or providers.

So at this point we'd like to bring Chantal on to talk about the outpatient update recommendation.

DR. WORZALA: Good afternoon. We'll be making an update recommendation for calendar year 2005. Under current law the update would be marketbasket, and the outpatient PPS update was not affected by the current legislation. The

Office of the Actuary estimates that spending under the outpatient PPS is $28.6 billion in 2003, about 38 percent of that spending coming from the beneficiaries. The outpatient PPS was implemented in August of 2010 and spending has increased dramatically sine then, rising 9.5 percent between 2001 and 2002, and an estimated 7.5 percent from 2002 to 2003. Growth rates going forward are projected to be 8 percent or so.

As Jack discussed, we consider payment adequacy for the hospital as a whole, mostly due to issues of cost allocations across service lines. Jack went through the major elements of payment adequacy from the framework. I just want to highlight a couple of items specific to outpatient services, including the share of hospitals providing outpatient services, increases in volume of services, and a quick look at the outpatient margin trend.

First, we've seen an increase over the past decade in the share of hospitals participating in the program that provide outpatient services. We see no change between 2001 and 2002. So the share of hospitals providing outpatient services and emergency services is high; 94 percent and 93 percent, respectively, and 84 percent of hospitals provided

outpatient surgery in 2001 and 2002, up from 79 percent in 1991.

In the looking at the volume of services under the outpatient PPS, there's been a very quick increase of 15 percent in the volume of services provided per fee-for-service enrollee. I want to note that this is an increase in the units of service provided, so not in the number of visits. There are a number of explanations for that very high level of growth, some of which are really more data and classification issues. But there is also an underlying real trend in volume growth. Anecdotal evidence and examination of the claims suggests that hospitals improved their coding between these years so they're coding more services in 2002 than 2001, even though they may be providing the same services. So units of drugs and things like that are more accurately coded, leading to the suggestion of greater increase than there might really be.

In addition, the payment system underwent changes in service definition, unbundling some things such as some drugs and blood products. This would also lead to an increase in units because we're now counting those as separate units instead of part of a bundle. But there is at

base some real volume growth. We know that in the payments increased 9.5 percent while the update was only 2.3 percent in 2002.

This is a preliminary look at the outpatient margins. We will be coming back with confirmation of these numbers in January as well as some of the distributions by hospital group. These are margins for all outpatient services, although for most hospitals the payments on the cost reports for 2001 and 2002 are 98 percent from the outpatient PPS because payments for non-PPS fee schedule items are reported on different worksheets than those we took our margin payments from.

We see you here a substantial improvement in margins that coincides with the implementation of the outpatient PPS, moving from negative 12.2 in 2002 to negative 6.2 in 2001 and then a drop from 2001 to 2002 to negative 6.7. The 2002 number comes from a sample of 60 percent of the hospitals. For the outpatient margins we did impute values for hospitals where we had a 2001 cost report and not a 2002 cost report.

Some explanation for the trend in the cost reports. There may, as Jack said, be some shift in the cost

allocation back towards the inpatient and away from outpatient. But we do also see payments increasing quickly. According to the Office of the Actuary there was a 16 percent increase from 2000 to 2001 for all outpatient services exclusive of lab, and then 9.5 percent from 2001-2002, 7.5 from 2002 to 2003. 2001 was also a period where the pass-through payments were not capped under the outpatient PPS.

This is also a period where the transitional corridor payments were being made. CMS had estimated that the transitional corridors would raise payments by 4.4 percent across all hospitals although we're seeing -- and I'll talk about this again a little later -- more like 2.3 percent of payments coming from those transitional corridors. But again, that's new money flowing into the outpatient system that would lead to improvements in the margin. Hospitals may also have been looking to control their outpatient costs in response to uncertainty over how this new payment system would work.

So that was a little bit of amplification of the payment adequacy specific to the outpatient PPS and now we'll turn to the update factors. First, of course, looking

at our best estimate of per-unit change in input prices. That's the hospital marketbasket increase. The latest estimate for 2005 is 3.2 percent.

Then when we look at the impact of scientific and technological change we see that there are already mechanisms in place to account for the cost of new technology in the outpatient PPS. We have the new technology APCs which pay for completely new services, and the services are placed in a new tech APC based only on their expected costs. We've seen a growth in the number of HCPC codes that fall into those new tech APCs from 75 services in 2003 to 88 services in 2004. There are an additional four applications under consideration at CMS with applications coming in and being considered on a quarterly basis.

Again, this provision generates a payment for each service and there's no budget neutrality constraint there so it's really increased expenditures. Our analysis of the claims show that in 2001 about 1 percent of payments went to the new technology APCs and in 2002 that rose to 1.5 percent.

The second technology provision are the pass-

through payments. Here we're really making an incremental payment for something that is in input to an existing service. This is budget neutral and the bulk of the pass-through payments have moved into the base payment system and now we're really getting new technologies flowing through this pipeline with a much smaller number. In 2004, there are nine device categories and 22 drugs with pass-through status. There are additional applications being received and looked at on a quarterly basis.

One last provision that will affect new technology and add additional money to the payment system is a provision in current legislation that sets a floor under the payment rates for drugs that is tied to AWP. This is not a budget neutral provision and CBO put an increment of $700 million between 2004 and 2005.

So for these three reasons we don't see the need for any kind of allowance for S&TA in the update.

Finally, we look at productivity. Again, the 10-year moving average of multifactor productivity in the economy as a whole is 0.9 percent. This is somewhat of an expectation that really ties productivity in this sector to the productivity of the people who fund the program.

Given these factors we propose the following draft recommendation for your consideration. The Congress should increase payments for the outpatient PPS by the increase in the hospital marketbasket less 0.9 percent for calendar year 2005. This recommendation would lead to a smaller increase in spending than current law, and we anticipate no major implications for beneficiaries and providers from this recommendation.

MR. HACKBARTH: So we still need to talk about the outlier issue for the outpatient. But before we turn to that why don't we address the update factors for inpatient and outpatient? Any questions or comments?

I have one. From my perspective the information, the breakdown of margins by type of hospital is going to be even more important than usual. The reason I say that is from my perspective one might feel very different about a 2.8 percent margin if there's a tight distribution around the average than -- in fact you might feel better about a 2.8 percent margin with a tight distribution around that average than you felt about a 3.9 percent margin with big, fat tails, including a lot of hospitals losing money.

I think directionally at least, one of the things

that happened with the reform legislation is that the number of hospitals losing money ought to be significantly reduced, certainly among the rural hospitals which were disproportionally in that group. I think that's consistent with what you said, Jack, about your thinking that the average margin for rural hospitals increased significantly. So I think it's not just the average that we need to focus on but also the distribution around the average, so I look forward to seeing those data.

DR. WOLTER: I guess I'll just express again, one of the concerns I have is in terms of how we look at our margin analysis sector by sector. On the one hand we say that we want to look at each sector and try to look at the information and make an update recommendation. On the other hand, we say cost allocation issues prevent us from doing that and, therefore, we should look at an overall Medicare margin. Today we heard that maybe the cost allocation decisions are being made in a reverse direction, so I don't know what we should do with that suggestion in terms of the outpatient recommendation versus the inpatient recommendation.

I know we can't fix this in the short run, but I

wonder as a commission if we should have a goal of moving to the day when we think the data actually helps us to make the decisions sector by sector, because it is difficult. It troubles me actually to find ourselves making these decisions in such a speculative manner.

The other thing I'm wondering about is if there was a year where the data would suggest that a full marketbasket on inpatient might be indicated this certainly would be it, from what I've just seen in terms of the increase in costs and the margins going down. I'm concerned about that, especially when you pair it with what still looks like a negative 6-plus percent margin on outpatient side.

Related to that, I would say that it was interesting what happened in recent legislation in that the full marketbasket update was at least paired with some reporting of quality data, which again as a commission we've said that we want to support. So I'm wondering if there's anything linking to that that we would want to consider in the terms of quality reporting on the inpatient side.

Those would be the issues I would raise in terms of this information.

MR. HACKBARTH: Do you want to respond to those?

MR. ASHBY: A couple of things I wanted to respond to there. First on the allocation issue. We can at least remind ourselves that our rather old data that we do have on what allocation is doing to the inpatient versus the outpatient margin suggests that the outpatient margin may have been understated by as much 15 percentage points. So while that's not a very precise measurement, I think there's really very little doubt that the real outpatient margin is now in positive territory with the minus 6 that we see on paper. There's still a lot of variation around it that we don't understand very well but I think we can at least say that much with confidence.

MR. HACKBARTH: Is it possible, Jack, as opposed to speculate about that, to systematically try to get a handle on it? I think that's what Nick is asking, can we advance beyond this point to where we'd feel much more confident that we know?

MR. ASHBY: We have a study underway that is designed to shed light on this issue. We will look at the allocation of cost that the hospital cost accounting systems can provide for us, and then restate our margins and see how

they come out. Now again, there's no perfect system here. We can never say the correct margin is whatever, but that will shed some light on the extent to which this allocation problem still exists, whether there's been any turnaround in the allocation. That will come up hopefully in the spring, late spring.

DR. MILLER: Could I just have at a couple things? I think we shouldn't be as strong as the statement of, we're clear at this point that the outpatient margin should be positive at this point. I think we don't know. I think it is a frustrating problem, and it's no fun for us to have to repeatedly have to come in front of the Commission with the data sources that we have and present what we have.

The other thing -- and I hate to be so negative here, but the other thing about this study that we're referring to is we'll have it if hospital systems choose to participate in it. If they don't, then it's not clear to me that we will have it. So we need to be clear when we make these statements, it depends on the participation of hospitals and their willingness to give us cost accounting data to do this. So it's a bit tough.

One last thing I'll say, and you've made this

point in the last meeting and we are trying to take it seriously and we are getting something of a push in this direction. There's a couple of provisions -- they're not quite on point to your concern here -- of looking at other data sources that are included in the bill that we have to do now as mandated studies, and it can give us a push in this direction. Because I think in the last meeting you said, at least in principle if we could articulate what kind of information at least and then, are there other sources? We will try to travel down this road. I just don't want to over-promise on this cost allocation study because if the hospitals don't step up we will have nothing.

DR. WOLTER: I think philosophically, if our framework is to cover the cost of an efficient provider sector by sector, that might lead to an agenda where we try to get the data sets that allow us to do that. Now it may not be possible, but it is a little bit frustrating when we are dealing with this blend.

Then back on the allocation or the outpatient side. This is just anecdotal so it's only worth that. But in visiting with my CFO and a number of others I get a fairly strong message that if that was occurring it

certainly hasn't been occurring in recent years, and that there may be issued around how hospitals allocate having to do with their fixed costs or their square footage or whatever, but that this really isn't an activity that they feel is very prominent at the moment, for whatever that's worth.

DR. REISCHAUER: Just a couple of questions about the charts. I wasn't clear, Chantal, if you gave us a reason why the margins seemed to plateau at minus 6 from 2001 to 2002. You'd be a lot more comfortable about the story that we've been telling if the pattern was minus 12, minus 8, minus 6, going in a direction and hospitals were slowly adjusting to the real world here. But when it levels off and then Jack says, when you put his set of glasses on he sees plus.

DR. WORZALA: I can talk a little bit about the change from 2001 to 2002. One thing is that the 2002 numbers are from a sample.

DR. REISCHAUER: Are incomplete.

DR. WORZALA: But in addition there were policy changes between 2001 and 2002, so the transitional corridor marginal payment percent was declining from 2001 to 2002.

In addition, 2001 is when a lot of excess dollars flowed through the pass-through mechanism and that did not happen in 2002. So there are policy reasons for that.

DR. REISCHAUER: So just to hold their own they would have had to have done -- something else would have had to have been going on.

DR. WORZALA: Right. In addition, as Jack discussed, we did see higher cost growth. He showed the cost growth per case, but these are really the same inputs whether it's inpatient or outpatient. We unfortunately don't have a unit measure for outpatient services on the cost report so we can't do an analogous assessment of cost growth per outpatient encounter or service or something like that. But the nurses are the same -- you're paying them the same whether it's inpatient or outpatient. A lot of the ancillary departments, it's the same inpatient and outpatient, so that cost growth would affect the outpatient as well as the inpatient.

DR. REISCHAUER: On that cost growth, is there any way to ferret out the increasing complexity of the average Medicare discharge? If the simpler things are going into outpatient over time and what remains is a resource-

intensive procedures with higher costs.

MR. ASHBY: Right. We have two potential measures, one is our normal case mix index across DRGs. It, I believe, is holding fairly steady. We could measure it with an APR-DRG system which would begin to pick up severity of illness, and we have not done that recently and I really can't comment. But we have not seen with the tool that we do have any significant increase.

However, I even have to caveat that by saying, you never quite know what the case-mix index, the degree to which it is measuring real resource changes or whether we're picking up coding changes. In recent years the coding emphasis has been downward, if anything, in response to all the inspection that's been going on and the like. So we saw a couple of years of actual declines in the case-mix index but we suspect --

DR. REISCHAUER: That was a couple years ago.

MR. ASHBY: Yes, that was a couple years back. Now it's stabilized and that's the best we know.

MR. MULLER: As we make the projection of the '04 margins, I remember the last couple years the industry groups would say that the costs are rising much more than

the marketbasket we're putting in. So for example, the 6.6 you showed today and I think you said it might have been 8.2 percent in '02, so if in fact the costs in '02 or '03 were really going at the 6, 8 percent range, is that what you're doing -- are you assuming that's what you're projecting the costs forward from the '01 based at 6 and 8 percent or are you projecting it forward at the 3 percent range?

MR. ASHBY: We began with a projection for '02 and we did pull in that full cost increase that we talked about here. We used a factor that's a sliver lower than the 8.1 because some of our reporters are actually pushing into '02. But we think that that reflects the full cost increases that were actually happening.

Then for '03 and '04 we do have somewhat of a standard there. We projected forward at marketbasket minus just half of the productivity increase. But that reflected a look at the cost pressures and evidence that some of the cost pressures are beginning to subside. We have evidence in the literature that the big push to hire nurses and other technical personnel is really abating. We saw the graph there that showed the wage increases rather abating. And on capital, as we said, we view that a little differently. We

probably will consider to have sizable cost increases as we measure capital expenses, but given the capital cycle it's not clear that that's something that we should be responding to. This is something that will have a cycle to it. We're in the upward part of the cycle, and we will later be in the downward part of the cycle.

So looking at all those things together it seems that a return to cost growth that's in the neighborhood of marketbasket seemed like a realistic possibility. But as we said, we don't really know. I think the best that we can do is look at it today and perhaps return a year from now and season the extent to which this is bearing out.

MR. MULLER: Then if it were a couple sixes again in '03 and '04 versus threes that would be a cumulative another 5, 6 percent which would take the margin not in the projected 2.8 but to negative territory. I'm just doing the arithmetic again, just Glenn's cautions.

MR. ASHBY: Indeed. After a number of years of that level of cost increase you'd really want to start to take a look at why we're seeing that kind of cost --

MR. MULLER: There's a couple things going on that, obviously hitting all of the American economy that's

been -- first of all, a lot of these hospitals are employers so they do pay health insurance premiums for their folks at a 10, 12, 14 percent range. Maybe not the marginal costs but there have been major increases to everybody in terms of pension costs the last few years. There have been major worker's comp increases and so forth. So when you look at the staffing cost, those things really start -- and maybe the nursing costs have slowed down but some of these other costs that are affecting all employers, not just hospitals.

So in fact I would not be surprised at all to see that in fact it has been another couple years of 5, 6 percent, and therefore the likelihood that when we do our updates -- when we show the data two years from now -- because really we were sitting here two years ago saying it's going to be say and the industry was coming in and saying it was six, and I think they were a little closer to the data. My guess is that's true again now. So that probably when we're sitting here two years from now we'll find that the costs went up 5, 6 percent each of the last two years and that the margins are not 2.8 but I think the margins probably are going to be less than 1 percent.

So when we look at adequacy, in some ways that

assumption that it's a 3 percent cost increase so dwarfs everything else we discuss here, so by making that assumption, is that assumption is really way off, we can be sitting here with an illusion that it's gone from 3 to 8, but it may have gone from 3-something to 0.5 very quickly based on some very really evidence as to how much the cost have gone up the last few years.

I understand that if the industry is not cooperating as fully as you want in terms of getting this cost data coming forth, then it's hard to -- other than using your marketbasket. But my sense is, in looking at it that we're going to be -- this 6 percent was quite predictable based on what people told us two years ago and it's going to be 5 to 6 percent again for '02 and '03 is pretty clear to me. So we can just put our projections down and see where we are two years from now but it's not going to be 3 percent for those two years that just passed.

MS. BURKE: I have two questions that I'm trying to understand. The first is, in the document on page 6 we reference the number and in fact reflect the tremendous increase in critical access hospitals from 375 to 835 in October of '03. The legislation as I understand it further

expands the definition and increases the bed size. So I would assume ultimately in the report we will speculate to some degree on how large this group is likely to become.

I wonder at some point, Glenn, over time if we ought not look at that. You're increasingly, again, get a larger and larger percentage of the hospitals that are outside of the PPS system. Admittedly relatively small, admittedly compared to some a relatively small impact. But nonetheless, that whole concept of moving large percentages -- I mean, we'll have a suspect somewhere in excess of 1,000 hospitals that will be outside the PPS. At some point that has to have some impact on how we begin to look at this system. I wonder at what point we should comment on that, and certainly in the numbers but also reflect on perhaps this is something that we ought to look at over time as we go forward.

The second question that I have, in the recommendation for the update for hospitals, going back to that, you recommend marketbasket minus 0.4. In the legislation as I understand it, they link a portion of the update to the willingness and the ability of the hospitals to submit quality data. Given what we now know and is

reflected in this document with respect to the increase in adverse events that occur in hospitals, some of that may be a function of reporting, better reporting. One wonders if there isn't a bit of that. But I wondered why we didn't pick up, or should we in fact pick up the linkage, begin to tie some kind of willingness or participation in the quality provisions as they relate to how we reimburse.

We have suggested in other aspects of our prior reports the desire, and we do it here around dialysis and a number of other areas, to begin to link, as we can, the legitimacy of a payment to a quality outcome. But this in fact is a data issue. That is, some kind of linkage to the hospital's willingness to report, and whether that isn't something we ought to think about as well. In this case we did a minus 0.4. In the case of the legislation as I understand it, it includes a 0.4 if in fact they are willing and then it minuses a 0.4 if they are unwilling to submit the information. I wonder if we had thought about that or is that --

MR. ASHBY: Actually the way the legislation reads is that it gives the actual update as marketbasket and then says they will be penalized 0.4 off if they don't provide

the data. That same feature could be attached to our recommendation.

MR. HACKBARTH: Let's have some discussion about that. That was also one of Nick's points.

My personal initial reaction was, if assessing processing quality is important, as I think it is -- I think it's vital -- why is it optional even with an incentive? Why isn't this a condition of participation in the program? That was my initial reaction.

Then the second one was, if we say for hospitals we're going to pay in some fashion for the data, does the same hold true for every other class of providers? For the combination of those two reasons I personally wasn't confident that this was a good precedent to set.

MS. BURKE: If I could respond. I recall, and Nancy-Ann will have to correct me -- we have in the past explicitly paid for certain kinds of data. We did it in Medicaid. We've done it in other places where we set a bar and say, we want you to comply with whatever it is, administrative flex -- whatever it happens to be. And we have been willing to incentivize people to move in that direction.

In this case, you're right, a condition of participation ought to suggest that they ought to do whatever it is that they ought to do. The complexity of the data collection and analysis -- I mean, we have added over time increasing burden in terms of what we are expecting facilities to produce, and this is certainly true at smaller units as well. The capacity of a hospital to do it, or any kind of organized system is far greater than it is at smaller units. Physicians' offices, we've admitted we have an enormously difficult time gathering that information and analyzing it on a per-unit basis. Organized systems could increasingly begin to produce it. The hospital though is the most obvious because it has the greatest demand in terms of what it is we expect of them today.

I agree with you, over time it ought to go in the direction where it is what we need, it is expected, do it. But I wonder, given where we are today, given that we've seen clear indication of an increase in adverse events, whether or not we ought to put an emphasis on it in the short term and then move towards it in the long term and maybe say that.

I don't disagree with where you want to get. I

just wonder if in the interim we ought not create some kind of strong message that quality increasingly is important and we're willing to try and help you produce that. And maybe over time we do it with the other facilities and the other providers as well.

DR. WOLTER: Just another point on that, because I agree with that and I think a second and third step, whenever it comes around, conditions of participation would be a great place to get to. As I understand what is going to be required in terms of tying in the legislation that payment to reporting it, it's data, but it's specifically reporting of measures being taken, process measures that have been shown to improve quality of care. So it really is linking what's being reported to activities which have been shown in the literature to improve quality. There's potentially some value in that in these early stages of trying to link payment to quality.

MR. ASHBY: Just one brief comment of the CAH issue. While I think we all believe we could easily be looking at 1,000 CAHs a year or two down the line, we also have to remember though that the equation has changed here. The payments are much more attractive now for small rural

hospitals under the provisions of the bill than they were, so I think there will be a lot of rethinking of the right decision here by some CEOs.

DR. WAKEFIELD: I was going to ask you that, Jack, whether or not that wasn't a possibility, that there may well be hospitals that are going to stay put because of those new provisions making that automatically default to a CAH not the better financial option.

MR. HACKBARTH: As I recall, that was basically the stance that we took in our rural report, was rather than have more and more hospitals opt out of PPS, let's fix PPS so it's fairer to rural hospitals and make it a viable opportunity.

MS. BURKE: Jack, you're absolutely right and I wonder if that's part of what we ought to look at in terms of what will happen. But you still have a large -- I mean, there is still proportionally a large number who have already, query whether or not more will because of the expanded definition or whether or not these payment adjustments will in fact satisfy what those needs are. But you have states -- I don't know if this is still true of Kansas, near and dear to my heart, but there was a point in

time when Kansas had 50 percent of its hospitals had fewer than 50 beds. You had geographically huge chunks that could move into these systems.

Now this may fix it. It may do exactly what has been proposed. But it seems to be we ought to be watching that to see whether or not it achieves what it intended to achieve, which is to equalize the system.

MR. ASHBY: Absolutely. We have a report coming up on the rural provisions and I think CAH as part of that is absolutely appropriate.

MR. HACKBARTH: Other comments on the paying for data issue?

DR. STOWERS: I was just going to back to what Nick said. I just don't think there's anything wrong at all with the Commission confirming the fact that it's okay to pay for data and to recognize the fact that data cost money to collect and that it's worth paying a little bit of money for that. And for the technology and medical record systems and so forth is a recognized expense in the hospitals. This quality is going to cost some money and that Congress is going to have to step up and help pay for it.

MS. DePARLE: If we're going to pay for that,

could we pay for quicker cost report or something that would give us -- seriously. That's been one of our big bones of contention is that the data that we use is always so lagged.

MR. HACKBARTH: I don't know how much of that is a hospital issue as opposed to a CMS issue.

MS. DePARLE: Yes, an intermediaries.

MR. HACKBARTH: Of course we could pay them for more data too.

Other comments on the data and payment issue?

Okay. Any comments on anything related to hospitals, inpatient or outpatient?

Hearing none, do we need to do the outlier thing now? Is that the next up?

DR. WORZALA: If you have the stomach for it. Switching topics a little bit, we'll talk about two issues under the outpatient PPS, the outlier payments and transitional corridor payments. We discussed the conceptual basis of outlier payments in October. I don't want to go over that here. Briefly, we framed the outlier as a kind of insurance, providing hospitals with financial protection in the event of extraordinarily high costs in comparison to their Medicare payment rates. The ultimate goal of that

kind of outlier provision is to protect access to care for beneficiaries that incur extraordinarily high costs.

During this presentation I'll review the outlier policy as it stands today, reiterate our policy questions and present some data inform them. Then I have three recommendation options for you to think about. Again, these are options and I would appreciate your feedback on them.

On the second issue, transitional corridors, I'll update you on the impact of the current legislation very quickly, because we covered that this morning, but then also give data from the cost reports on the importance of these transitional corridor payments for different types of hospitals. I would like your guidance on whether to pursue that particular issue any further.

The outlier policy for the outpatient PPS is required by statute. Like the outlier policy in other settings it must also be budget neutral. Therefore, CMS reduces payments for all APCs to fund the outlier payments. Congress set an upper bound on the outlier payments of 3 percent. CMS has so far targeted outlier payments below that limit. In 2003, the target was 2 percent and that will be maintained in 2004. If actual payments exceed or fall

below that target amount, no effort is made to modify the conversion factor to recoup or return over or underpayments.

In 2003, the outpatient PPS provided outlier payments to all APCs except for pass-through drugs and devices. This was regardless of the payment amount for the service and includes both broadly defined APCs such as surgeries, and narrowly defined groups such as an x-ray or an echocardiogram. The recent Medicare legislation will remove separately paid drugs from receiving outlier payments effective 2004.

CMS estimated that a cost threshold of 2.75 times the payment rate for the APC and a marginal payment factor of 45 percent of the cost above the threshold would result in outlier payments that meet the target of 2 percent. I believe there's a discrepancy between what's in front of you and what's on the screen with the cost threshold. It is 2.75 not 3.5.

How do the fiscal intermediaries calculate the outlier payments? Basically, outlier payments are based on estimated costs since those costs are estimated by the fiscal intermediaries by multiplying current charges on a claim by a cost to charge ratio from the most recent

tentatively settled or settled cost report. Even using that most recent tentatively settled cost report generally results in a time lag of one to two years between the calculation of the cost to charge ratio and the submitted charge on the claim. So if the charges have increased at a faster rate than the costs since that cost report period, the CCR will result in an estimate of costs that are higher than the actual costs.

There are, of course, many reasons for a hospital to increase charges faster than costs, and no matter what motivation this pattern would result in unwarranted outlier payments. Since this is a budget neutral system those are paid for by other hospitals. Since the outliers are budget neutral that has distributional effects.

This slide shows the historical relationship between cost and charges since 1985. The metric here is the ratio of cost over charges, so a lower value indicates that charges are higher than costs. This is a CCR on this chart for all patient care service not just outpatient services. But what we're looking for here is the trend over time. You do see a secular trend of charges rising faster than cost among all hospitals. With any of these metrics there can be

variations across hospitals. We do know that there were some hospitals that were very aggressive in raising their charges.

So as I mentioned there is this time lag, which means you are overestimating costs if you use an older cost to charge ratio against the current charges on the claim.

CMS has done quite a bit to limited this problem. They have required that the FIs update their CCRs whenever a new cost report is submitted or settled. They give a very short time window for the FIs to do that. And they have changed a provision where if a CCR seems exceptionally low they simply verify that that's the correct CCR rather than substituting a state-wide average CCR. Nevertheless, this problem is inherent in the calculation of outlier payments.

There's an additional issue that arises here because the FIs are calculating a single hospital-level outpatient-specific cost to charge ratio. We know, however, that the relationship between costs and charges can vary by service depending on the hospital charge structure and how much they mark up one type of service over another. So if one department routinely has a higher markup than the average, the estimated cost for services in that department

will be overstated, and those services attract more outlier payments. Then the opposite is true for a department that has a lower markup.

One thinking about this, it's parallel in some way to the coinsurance structure under the outpatient PPS where coinsurance what was based on charges. If you look at the coinsurance rates you see a rate closer to 50 percent for things like imaging, departments where we think the markup is higher versus other services, some of the clinic visits and things where we think that the markup might not be as high. So keep that in mind as I show you some of the service level results in a few minutes.

What are our policy questions that we're trying to address? First, does the outpatient PPS need an outlier policy? Second, if it does, what is the appropriate design?

In October we discussed at some length this first question. I'll quickly summarize the arguments here since some time has elapsed. There are a number of reasons to think that the outpatient PPS does not need an outlier policy. First, there's a very narrow product definition and we have many ancillary services and inputs such as drugs, x-rays, that are paid separately, leading us to think that

variability in costs will not be great.

Second, the APCs have low payment rates, which means that the size of the potential loss from any given service is generally quite small even if it's very costly in comparison to the payment rate.

Third, there are some equity issues. This is a budget neutral system so the base payments have been lowered to fund the outliers, and the outliers are not evenly distributed. So there are some distributional effects. In addition, there is potential for outlier payments to be made in response to increases in charges, not necessarily increases in costs. Again, since this is budget neutral it may be more equitable in fact to have no outlier policy.

Finally, the outpatient PPS is the only ambulatory care setting with an outlier policy, but many of the services provided there can be provided in physicians' offices or ASCs, so you're creating on more difference in how we pay for these services across settings, which is a larger payment question.

It despite those no arguments there are some arguments to maintain the outpatient outlier. First, we do see a shift toward more sophisticated and more costly

services moving to the outpatient setting, outpatient bone marrow transplants, outpatient mastectomies, things that are fairly significant procedures, in addition to cardiac catheterization, implant of cardiac devices, those sorts of things.

Second, the outpatient PPS is a fairly new payment system. It's been a little bit difficult for CMS to set the payments given the data that they have available and hospital coding practices and those sorts of things, so the outlier may be providing a cushion for rates that are actually too low. It would be better to fix the payment rates, and I think as the payment system matures there will be less of an issue there. But in the interim, maybe the outlier payment is serving a purpose there.

Third, we do see that there's a potential for distribution of cases across hospitals that is not random. Some hospitals may have more expensive cases on a routine basis and the outliers would help cushion the impact of that for those hospitals.

Moving on to the second set of design questions. Here we're really looking at how, assuming we want to keep an outpatient outlier policy, how would we determine

eligibility, how shall we set the threshold, and indeed, how much funding should there be if we change either the eligibility or the threshold? Very quickly, you've seen this slide before. Most APC groups have low payment rates per unit. Two-thirds have payment rates of less than $500 and 75 percent have payment rates of less than $1,000. There are some high-paid services, insertion of a cardiac defibrillator is about $17,000.

Here we look at the services receiving the most outlier payments in 2001. First of all, almost all APCs received at least some outlier payments, but a relatively small number, 26, accounted for 50 percent of the outlier payments. These same services accounted for only 38 percent of the payments. The nine services on this chart -- obviously I couldn't put all 26 on there. The 26 are in your briefing materials. The nine on this chart account for 29 percent of the outlier payments and 25 percent of APC payments.

In looking at this chart we see that the payment rates for all of these services that are the top outlier getters are low, under $400. This first service that received 6.6 percent of the outliers is infusion therapy

except chemo. We might expect considerable variation in the cost for this particular service because there are packaged drugs and infusion fluids in the payment rate and that may vary quite a bit by patient. However, CMS is now paying separately for many drugs and there's this floor under drug payment amounts so moving forward we may not expect as much variability for this APC.

The next two services, the CT and the x-ray seem to have less intuitive rationale for variability in cost and the need for outlier payments. I'm not quite sure what an outlier CT is. One thing that I should say, however, is that these are very common services. So for example, the x-rays, where you see the share of the payments and the share of outliers being the same, random variation could explain that but I think we have a question of whether that the kind of service that we want to protect given that it's a payment rate of $40.

MS. DePARLE: Chantal, can you walk through 0260 level one x-ray $40. What does that mean? How do you qualify for an outlier payment?

DR. WORZALA: You have costs that are -- we'll just say that the threshold is three times, so you have

costs that are more than three times the payment rate. So you're reporting costs from your x-ray that are $40 plus $120, $160 and then you qualify for an outlier.

MS. DePARLE: So for an individual patient your costs were 2.75 times the $40?

DR. WORZALA: Correct, and then we're paying a fraction of the cost about that threshold.

MS. DePARLE: Clinically, what would have caused that?

DR. WOLTER: I was just trying to figure out what it might be.

DR. REISCHAUER: Couldn't all of your x-rays fall into the outlier?

DR. WORZALA: Yes, all of your x-rays could fall into the outlier.

DR. REISCHAUER: So it's a hospital that has very high charges for this.

DR. WORZALA: Yes. Let's focus a little bit on --

DR. WOLTER: It probably wouldn't be worth knowing although it may be that at that low a payment rate it just doesn't matter, but you might wonder is it somebody in the emergency room who has a neck injury and getting a c-spine

film is very difficult and it takes multiple views. You could imagine some clinical reasons but I honestly don't know.

DR. NELSON: I know you want to move on but while we're on this subject with our hypothetical chest x-ray that goes off the top of the chart, is the patient insulated from -- in their copayment?

DR. WORZALA: Yes. Only the program pays an outlier payment. The beneficiary only pays their copay.

DR. NELSON: So is the patient's copayment higher?

DR. WORZALA: No, it is not.

MS. DePARLE: So the patient's copay is only based on $40?

DR. WORZALA: That's correct. Focusing on the cost to charge ratio, if we look at the electrocardiograms, they receive 3 percent of the outliers and were only responsible for 1 percent of the payments. The table in your briefing materials has another column that looks at outlier payments as a share of outlier plus APC payments. For this particular service, 12 percent of the total flowed through -- 12 percent of total payments for electrocardiograms came from the outlier payments. I think

this may be an example of a service that has a higher than average markup.

Moving onto outlier payments by hospital group, we're looking at the distribution of outlier payments among hospitals across three different groupings, location, teaching status, and ownership type. In each group we're seeing that one type of hospital received a greater share of outlier payments compared to APC payments than others. It doesn't, however, tells us why. These relationships could be explained by differences in patient mix, could be explained by differences in cost, it could be explained by differences in charge structures. These numbers are from 2001. We have also just analyzed the 2002 data and we'll bring those results to you in January.

The top right number there of 3.3 percent indicates that in 2001, if you took outliers over the sum of outliers plus APC payments the outliers were 3.3 percent of the total. This is a ratio from the claims. There's no transitional corridors. In 2001, the target was 2.5 percent, so it's slightly higher than the target. However, when we look at the 2002 claims it drops down to closer to 2 percent. So I don't want people to take this away and think

there's a major problem. This was 2001. 2002 is closer to 2 percent. However, in both years the patterns across the hospital groups are similar.

One other note, both of these two years precede implementation of some of the steps that CMS has taken to limit gaming, so the CCR calculation -- this involves older CCRs I guess is what I would say.

So let me take your attention to the final column which again is outliers as a percent of all payments. By location, hospitals in large urban areas received 4 percent of all payments from the outlier. For other urban and rural hospitals it was lower, 2.6 or 2.7 percent. If you look at it by teaching status, outlier payments accounted for 5.3 percent of payments to major teaching hospitals. It was lower for the non-teaching groups or the other teaching group. By ownership we see that the for-profit or proprietary hospitals received 5 percent of all payments through the outlier mechanism.

I also did an analysis looking at the distribution of outlier payments as a share of all payments for individual hospitals. Looking at that we see that 50 percent of hospitals had outliers that were 1 percent or

less of total payments, 75 percent had outliers that were 4 percent or less of total payments, and at the other extreme, we had 1 percent of hospitals where outliers represented 30 percent or more of payments. There I only include the hospitals we know from analysis from CMS, but for the community mental health centers it was closer to a one-to-one ratio of outliers to base payments. I also required that the hospitals have at least $1,000 in payments for that analysis.

In summary, since I've shown you a fair amount of data, we know that most outpatient PPS services are narrowly defined and have low payment rates. We've seen from the data that most of the services receiving the greatest share of outlier payments have low payment rates and are narrowly defined. The data also show that the distribution of outlier payments varies by hospital group and individual hospital. These differences could be due to differences in patient mix, cost structure, or differences in charging practices. It's probably a mixture of all three.

Finally, we think that the calculation of the outlier payment makes it susceptible to gaming. Although to be fair CMS has taken some steps to limit those

opportunities, but there is still nothing to stop a hospital from taking a commonly-provided service and increasing their charge for that particular service and getting some outlier payments that way.

Given these conclusions I'll present you with -- I'm sorry, there's one other global comment I wanted to make which is that looking at this data I'm not sure it's clear that the outlier policy is really protecting hospitals from large financial losses, at least in the bulk of the outlier payments. Therefore, I'm not sure that it's having a lot of impact on beneficiary access to care. We may not be making outlier payments in cases where patients truly are more costly I think is what I'm saying.

So with that context we have three recommendation options. Again these are options. The first option is you do this and you don't need to do the other two. The other two you could do in some sort of combination.

The first recommendation option would be that the Congress eliminate the outlier provision for the outpatient PPS. The spending implications of this would be nothing. The provision is budget neutral and presumably the funds would go back into the base conversion factor. The impact

on beneficiaries and providers, it seems unlikely, given what we've seen, that this would adversely affect beneficiary access to care. But we do know that it would redistribute payments among hospitals when you shift funds to the base.

Recommendation option two read that the Secretary should introduce a dollar threshold to the outlier policy under the outpatient PPS. The Secretary was given authority to do this under BBRA. The spending implications would be none since it's budget neutral. I would think that this would actually better protect beneficiaries with extraordinary high costs because you could focus the limited funds that are available in the outlier to those that are truly extremely costly. It would probably result or may result in a redistribution of outlier payments among hospitals.

The third option takes a slightly different approach to modifying the outlier policy looking at services as opposed to a dollar threshold and it read that the Congress should give the Secretary the authority to limit the kinds of services eligible for outlier payments under the outpatient PPS. Currently by law all services must be

covered unless stated otherwise in law, and we do have this example of the separately paid drugs now not being eligible for outlier payments. Here the spending implications, none; and for beneficiaries and providers would probably better protect beneficiaries with extraordinarily high costs and may result in the redistribution of outlier payments.

MR. HACKBARTH: Questions, comments?

MS. ROSENBLATT: Just a quick comment. I think the chart on page 10, the one that we were all getting excited about leans me towards recommendation number three, because if I look at 0612 high-level ED visit, just reading that you would think there would be clinical differences there. So I think option three captures that, that there will be some. But like we were talking about the x-ray, I don't buy that one. So I would vote for three.

DR. WORZALA: I just want to say one thing about emergency services that I'm not sure I said. I did in the paper, and I did another analysis in the paper that I didn't even present here because I felt like it was data overload. But the payment system for emergency services is that there's a payment for the visit. So for the assessment, the triage, that sort of thing. But everything that's done

during the emergency visit is also paid. So if you get a cast, you need an x-ray, those services also ring the register, as it were.

The analysis that I did on a claim-level basis as opposed to a service-level basis was really trying to get at this notion of whether or not outlier payments were concentrated on people where you thought there would be variability like emergency services. So I categorized each claim as being an emergency visit first, hierarchical determination, and then after that a major procedure, after that chemotherapy, trying to say, why would you come to the outpatient department. When you look at it that way you still don't see that there's a lot of outlier payments coming to emergency visits, which I thought was rather surprising. It had an even outlier and total payment percentage.

So conceptually you would think that was true. The way the system is working currently it's not true. But I did want to make clear that we're not talking about all of the services provided in an emergency visit when we take that code 0610.

DR. REISCHAUER: Why isn't it practical to have a

clawback provision that whenever an audited cost report is completed you plug it into the computer and it goes back and calculates the over or underpayment in the outlier system, which would remove a tremendous of the incentive here? With interest.

DR. WORZALA: I believe that is being done for the inpatient outlier. On the outpatient side we do have millions and millions of claims, so I think it would be a fairly significant administrative effort to do that. It's certainly not impossible.

DR. REISCHAUER: That's why you have computers. They do these kinds of things for you.

DR. MILLER: Do we have any sense of -- this is probably not a fair question but do we have any sense of how many and how long it takes for completing an audit report?

DR. REISCHAUER: So what? You're removing the incentive.

DR. MILLER: Eliminating it would too.

MR. HACKBARTH: Let me ask this. Is there any sentiment in favor of just eliminating outlier payments, which I think was option one on Chantal's list? Any sentiment in favor of option one which was to eliminate

outlier payments altogether for these services?

MS. DePARLE: It would just mean that the 2 percent would be preserved in the spending on outpatient services?

MR. HACKBARTH: Yes, go back into the base. So it would have distributive implications but not aggregate spending implications.

MS. DePARLE: Alice made the most compelling case. Sitting here looking at it I'm embarrassed that we even implemented this, frankly. I don't understand it.

DR. WORZALA: Don't be too embarrassed. The proposed rule didn't have an outlier and it was mandated by Congress.

MR. HACKBARTH: I guess I'd worry some about there being some variability, particularly in the services that involve larger bundles, so to speak. The cost to charge ratio is just so problematic that I wonder whether we do more harm than good using that mechanism. It rewards gaming of the system and the dollars just may not be getting to the right place at all.

MS. ROSENBLATT: In small amounts you're multiplying by three. It's pretty easy to get there it

sounds like.

DR. WOLTER: I suppose one option would be to combine two and three and suggest that a more limited universe of outliers be created looking at services and dollar bundles so that there's still some flexibility and yet we're moving in the direction of taking a lot of the gaming out of the system especially for the small dollar numbers.

MS. DePARLE: Nick, I hear you but the agency has to implement all this stuff in the Medicare bill plus a prescription drug benefit. Is it really worth it? Is this achieving -- I guess we need to hear from some hospitals that think it's really doing something to help them meet the needs of their patients. But so far I don't think this would be worth having spent at CMS spend time trying to get this right.

MR. MULLER: First of all, I would say that, as Chantal's presentation indicated, we're finding out some data on '01 now, so I think the outlier provision was put in more when we didn't know what was going to happen. If we go back three years there's incredible uncertainty as to what actually was going to happen, whether the APCs were even

remotely on target or not. We had all those corridor payments and hold-harmless and all that kind of stuff, as you know. So I think now three years later we know a little bit more about it and it turned out to be a little closer to where people hoped it would be as opposed to just being way off the mark in terms of meeting costs and so forth.

So I think this probably less thrust for it now than there would have been three years ago when there was all kinds of uncertainty. So in some ways, one way of making an argument against it in some ways is saying, three years later, now that we have some data on 2001, it doesn't seem that we were as far off as we might have thought we were and we made all those kinds of protections. I think in some ways there was a fear that on some of these services one could be off 50, 80, 100, 200, 300 percent, and there is not substantial evidence that that in fact has occurred. So that in many ways could be a persuasive argument for saying, doesn't seem to be as big a problem.

On the other hand, not all these are totally narrowly defined and the purpose, as Glenn just said, of having outliers sometimes -- we have 570 APCs, we have 510 DRGs, so it isn't as if -- to use arithmetic, to use the

phrase of the day -- the bundles aren't that much more narrow than some of the DRG bundles and so forth. So you could make an argument by having some possibly, and one thing to do is just you can kick the threshold up even more, is one way of really making a note for the very extreme cases. So I think having a couple suggestions on that, but I think one fair statement is this is the first time I've really seen data on this in terms of what happened in '01 so I think letting people start understanding what actually happened is going to be helpful.

MR. HACKBARTH: The problem, of course, with just kicking up the thresholds is you're still relying as your basic took on the cost to charge ratio which is so problematic, which is I'm sure where Bob's coming from in saying, if you can do something that would reduce the opportunity, the incentive to manipulate that number, that would give you some confidence then you could have a system maybe with higher thresholds and it be reasonably fair. But right now it's just --

MR. MULLER: You have a cost to charge ratio for the whole hospital. You don't have it -- you can't do one on cardiac and another one on oncology. You can't just

manipulate it that way.

MR. HACKBARTH: The graph that Chantal showed, over the last 15 or 20 years, the decline in the aggregated cost to charge ratio from 75 down to 42, that just screams at you this is a giant game. If we continue on this rate for the next 15 years we're approaching zero on our cost to charge ratio.

DR. REISCHAUER: Even if you did what I suggested, you could manipulate the cost to charge ratio for services that were heavily used by Medicare patients versus other ones and the hospital's ratio on average would be a biased thing, so there's still a game to be played.

MR. HACKBARTH: So I think I hear consensus that the status quo is not desirable and we need to make a change here. The options on the table are eliminate completely or maybe do a combination of two and three, which is focus on our services with some variability and have the front-end threshold.

DR. WORZALA: We can also pick up Bob's suggestion of asking the Secretary to settle the outlier payments on the cost report, which is what they're doing on the inpatient side. But before we do that I would like to

better understand what that would entail on the part of the agency and the FIs.

DR. REISCHAUER: We could mix all three and have this phase out but in the first stage being we raise the threshold, give the Secretary a little bit of flexibility to bump out some things that shouldn't have a lot of variability, reduce the aggregate to 1 percent or something like that, and then three years have it disappear.

MR. HACKBARTH: We don't need to resolve this today. Any other thoughts that people want to give Chantal to look at in the next month?

Okay, thank you very much.

DR. WORZALA: Actually I forgot until Sarah mentioned that there's some data on transitional corridor payments. Do you have the stomach for that after all this?

MR. HACKBARTH: Sure.

DR. WORZALA: I think I will skip over the set-up for the transitional corridor payments unless anyone feels like they need a review of what they are or how they work, and get to the data since again this is something that has not been seen. One thing I will point out is that the calculation of the transitional corridors is also dependent

on the cost to charge ratios because we first must estimate the cost in calculating the payment, and there's an interim payment with settlement on a cost report.

These are data from the 2001 and 2002 cost reports. What I'm looking at here are the share of PPS payments that came through transitional corridor payments. So it's transitional corridor payments divided by PPS payments plus transitional corridor payments. The 2001 number I believe is about 95 percent of hospitals. 2002 is 60 percent with no imputation for missing hospitals.

We can see that altogether in 2001 these payments represented about 2.3 percent of all payments, rising to 2.6 percent in 2002. That compares to a projection of 4.4 percent on the part of CMS when they put the rule out. So we might conclude that hospitals are actually doing better transitioning into the PPS than was expected. Alternatively, you could say that the data available to CMS when they made that estimate wasn't the best and they did the best they could with the data and there's a difference there.

It's a bit surprising to see an increase in the transitional corridor payments rather than a decrease since

the policy is supposed to be phasing down traditional corridor payments. That trend may not hold with a full sample of hospitals. But it could be a real phenomenon if the difference between PPS payments and payments estimated from previous payment policy grew by a fairly substantial amount between those two years. Again that would involve cost to charge ratios and payment to cost ratios in making those calculations.

If you look at these shares you see that small rural hospitals received a greater share of total PPS payments from transitional corridors. The rural one to 100 beds, it was 4.7 percent in '01 and 6.4 percent in '02. Also we see that the major teaching hospitals report a higher share of payments from transitional corridors as well, about 5 percent in each of the two years.

As we talked about this morning, the current legislation does extend those hold-harmless payments for the small rural hospitals for two years and also extends them to all sole community hospitals regardless of size. About 85 percent of the sole community hospitals have 100 or fewer beds. It also requires a study by the Secretary of the cost of rural hospitals compared to urban under the outpatient

PPS and a look at the need for a payment adjustment for rural hospitals.

We had put this on our agenda for this year because our 2001 report suggested that there may be some factors that would make the outpatient PPS more difficult for small rural hospitals to adjust to. We've been a little bit frustrated over the last two years that there hasn't been any data, which we now have of course. But I don't know that, given the current legislation, the Commission wants to do anything else with. So I bring that for your direction.

MR. HACKBARTH: Comments?

DR. WOLTER: A question. I didn't quite catch that. The legislation extends this to sole community hospitals; is that what you said, or what bed size?

DR. WORZALA: Any bed size. However, about 85 percent are 100 or fewer beds. So there are about 15 percent of small community hospitals who will benefit from this provision that didn't previously, so it comes with a small price tag.

MR. HACKBARTH: I'm sensing that we're at the end of our useful life for today. We're going to take this

other advisement I think it and retire to our chambers.

Thanks, Chantal.

DR. WORZALA: Please let me know if you want additional analysis by January.

MR. HACKBARTH: We'll have a brief public comment period.

MS. FISHER: Karen Fisher with the Association of American Medical Colleges. I wanted to jump in first because my comment relates to your most recent topic on the outliers. I'm going to continue the analogy of not doing math in public, I'm nervous because I've been thinking and I'm going to think in public here and that may not be a wise thing.

The issue of the outlier payments, first of all I would say teaching hospitals are in favor of accurate costs because teaching hospitals, we believe, tend to treat the complicated cases. When you look at accurate costs -- and that's the intention of the outlier payments. When you have a set pool of money, if there are people who don't have accurate costs, it takes money from those who have accurate costs for high-cost cases.

There's the issue of what do you do with the cost

to charge ratios, et cetera. The inpatient outlier final rule last year -- and I've been informed by my colleagues that this whole issue of using more recently settled and submitted cost reports to try to eliminate the lag period with cost to charge ratios we think is going to eliminate a lot of the gaming that was associated with the outlier rule.

The issue of going back for egregious people and trying to settle I also hear from my colleagues is limited to the inpatient only, and I think it's a reasonable thought for this Commission to think about on the outpatient side.

I would say that we also have to remember that CMS has shown that for high-cost services the markup tends to be less than for overall services. So when you look at that cost to charge ratio and you look at the high-cost, complicated services, this issue gets a little bit more complicated because the markup is not as high for those services.

I'm a little quizzical about the impact on the beneficiaries under the three options. It seems to my under option one, to eliminate it, we're not sure what the impact is on the beneficiaries because we're not sure what the impact of eliminating the outlier policy would be on the

low-volume, high-cost services because they don't show up in the outlier tables contributing to the large amounts of the outlier payments.

On the second two options we say it better protects beneficiaries if we limit it to higher-cost services or to a certain set of services. I would say that if you just do that it would have no impact on beneficiaries because that's what's occurring now. It's occurring now for those high-cost services as well as the low-cost services. What would better protect beneficiaries though is that if you limited the number of services that would be eligible for an outlier payment but then increase the outlier payment threshold, which is currently at 45 percent, we believe that if you're truly dealing with accurate costs and you're limiting the outlier payment policy to the high-cost services, why are you only paying for 45 percent of the costs above the threshold, which is already twice what the cost amount is? So it's quizzical why you wouldn't increase that threshold.

We would suggest if you go down a path of limiting the number of services and the types of services that would be eligible for an outlier payment that you give serious

consideration to increasing the outlier payment percentage that those services would be eligible for.

We're also concerned because if you again look at the data and believe that major teaching hospitals tend to provide a number of these services and then you look at the transitional corridor payments which are going to be eliminated for major teaching hospitals at the end of this year, and if you believe some of the reason for the transitional corridor payments is because they're providing high-cost services, the need for an outlier payment policy in the future is more important than ever.

Thank you.

MR. ARMSTRONG: I'm Doug Armstrong. I'm with AAHP-HIAA. We are the nation's trade association representing about 1,300 of the nation's health insurers, including those that provide coverage to more than 200 million Americans. I'd like to say that I'm having a little bit of difficulty in reconciling the inequitable way that the Commission is recommending incentives for quality. This morning the Commission recommended withholding 2 percent of all plan payments and then rewarding only those certain plans that meet or exceed certain quality thresholds. While

this afternoon the same commission recommended withholding just 0.4 percent of inpatient payments and then returning them to all facilities that only have to meet reporting requirements with no accountability whatsoever for meeting or exceeding any sort of threshold. This seems to be very inequitable, and it is.

What it actually does is it completely discriminates against one portion of the health care delivery system and that's the insurers. I know that we would greatly appreciate you re-examining what you're using as carrots and sticks as providing incentives for quality throughout the health-care industry.

MR. MAY: Don May with the American Hospital Association. I want to thank you for a very rich and lively discussion today that kept the room pretty full even if we are at the end of our useful life for the day. A couple things. One on outpatient, to start there and the outlier provision.

I think we feel, as Karen mentioned, that there does need to be an outlier provision. Outpatient services are changing. Many more things can be done on an outpatient basis. We don't know what the cost of those are going to be

and it probably makes sense to have an outlier policy.

That being said, having it pay at a very discrete level, at a very small bundle probably doesn't make as much sense as expanding -- either by setting a higher threshold or by looking at all the services provided on one day. I don't know if that's at a claim level, because I know the data is very complicated, but in a visit, when you come to a hospital, maybe look at what the costs are for that day, accumulating the cost for a visit, regardless of how many APCs are there, see if that was a high-cost patient because of all the multiple things that had to be done and then compare what the payments were to try to get at a better, reasonable outlier system in the outpatient program.

Like Karen, I think that a lot of the changes that CMS has made around cost to charge ratios and using more current data to get there has gone a long way and will go a long way in addressing some of the data concerns that show in this old data, but this old data, as she mentioned, doesn't reflect some of the changes in policy.

I would say, however, that we would very much urge you not to recommend cost settlement of outpatient claims. That would require regenerating every single claim using new

cost to charge ratios, and there are many, many more outpatient claims than inpatient claims. It would be a very, very burdensome approach at looking at outliers and is something that we would be very concerned about that excess burden put on the system.

On to payment adequacy and the update recommendation. When I look at the data and I look at Medicare margin dropping every year since 1997 I look at the trend in the overall Medicare margin dropping and the projection for it to drop in 2004 again. What I see is declining payment adequacy and really we don't have payment adequacy in Medicare. That's why Congress passed a prescription drug bill with many provisions in it to help rural providers, other providers, other hospitals, because the payment adequacy isn't there. You have more than half the hospitals in the country losing money providing care to Medicare patients. That is inadequate.

When you look at that aggregate and you say it's at 4 percent or 3 percent or now it's at 2.4 percent and things are still adequate, that does not take into account the variability and it doesn't allow you to move toward where we need to go in improving the technologies in our

hospitals, the information systems, building average age of plant, which is at its oldest in years. So I really would urge you to rethink what we're determining is adequate because I don't see adequacy in those numbers.

As far as the whole cost allocation issue, I think we heard today arguments for the cost allocation is still an issue, arguments by the same staff that cost allocation may not be an issue. I really think we should just start showing the margins. The home health margins in hospitals are deplorable. That's why we have hospitals getting out of that service. They can't afford to provide the service. Regardless of how you look at cost allocation, hospitals and organizations are making decisions based on whether they can afford to stay in that line of business, whether they can afford to do that for their communities, and clearly they can't. So cost allocation aside, the home health margins by hospital-based providers are falling and dropping and that's why hospitals aren't able to provide those services.

If you look at some of the blanket terms on capital, access to capital is still a struggle for many hospitals. More bond downgrades than upgrades, and with a downgrade comes, even if you have investment grade, more

expensive cost of capital. We just showed the cost of capital was going up. That is a reflection that hospitals have reached a point where they have to invest in their infrastructure. They're doing it at a higher rate. So I really would challenge the Commission and the staff to look at some of the access to capital arguments because we really do see with half the hospitals not having positive Medicare margins, a third of the hospitals losing money overall, there really is an access to capital problem. With all of the demands on hospitals to improve infrastructure, to improve information systems, to address some of the quality and patient safety issues, these are very expensive and those cost increases are very real.

On the science and technological advancements, and this is particularly for outpatient but I thing it applies to inpatient as well. While there are some mechanisms to pay for certain clinical devices or new drugs, remember that science and technological advancement and the science and technological advancement in health care that's going to be the breakthrough that will all of a sudden allow us to lower length of stay again is not necessarily just a drug, but it could be information systems, it could be other things in

the hospital that aren't necessarily tied to a service but may be tied to many services. I'd encourage the staff when they talk about science and technological advancement to really talk about all of science and technology, not just the clinical components.

On productivity, we continue to be very concerned about the use of the productivity adjustment, the 0.9 percent reduction of the general economy's multifactor productivity growth. To think that one industry can continue to have productivity gains year after year after year is probably asking a lot. That general economy is based on the cumulation of all the industries going up and down on an annual basis. But to expect that the health care field and hospitals in general should be able to hit that every single year I think is somewhat ambitious.

I also believe, and we've been doing some work on this issue, that when you look at the industry, health care and hospitals are very labor intensive. There's a lot of evidence out there that suggests that the more labor intensive an organization is, the much more difficult it is to have the same types of productivity gains for lower labor related industries. I think, based on some of our

preliminary work, the general economy may be overstating by as much as twice the rate of productivity that can be gained in an industry that heavily relies on labor. You saw those labor costs driving up cost of hospitals; the 6.6 percent increase, the cost that Jack suggests might be happening in 2002 primarily being driven by labor.

I would argue that it's very difficult to suggest that there is going to be a productivity adjustment of 1 percent when you've got such a labor-driven group, yet we're going to take away billions of dollars with that adjustment assuming that we can just take out 1 percent out of -- in productivity on an annual basis when it is something that's focused on labor.

But those are just some of the comments. We will, obviously, be sharing more information on this productivity analysis. We'd just encourage you to rethink about this issue of payment adequacy and whether with a productivity of minus 1 percent really make sense given the cost trends that we're seeing.

Thank you.

MR. HACKBARTH: Thank you. We reconvene at 9:00 a.m.

[Whereupon, at 5:48 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Friday, December 5, 2003.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

**Friday, December 5, 2003**
**9:05 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
NANCY-ANN DePARLE
DAVID F. DURENBERGER
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

AGENDA PAGE

Quality of care provided to Medicare beneficiaries -- Karen Milgate, Sharon Cheng, David Glass, Sarah Lowery 281

Ambulatory surgical center services: assessing payment adequacy and updating payments -- Ariel Winter 328

Skilled nursing facilities: assessing payment adequacy and updating payments -- Susanne Seagrave 359

Public comment 379

P R O C E E D I N G S

MR. HACKBARTH: Good morning. Our first topic for this morning is quality of care.

MS. MILGATE: What we're going to do in this session is provide you some data on the quality of care Medicare beneficiaries receive. We're excited about presenting these data for, as a recent article noted, surprisingly little has been written or presented about the quality of care Medicare beneficiaries receive, even though they represent 40 percent of all health care expenditures.

While the data we'll present to you do not provide a comprehensive view of beneficiary quality, they do include information on clinical effectiveness, patient safety, timeliness, and the patient-centeredness of care, which are the four primary dimensions that the IOM has identified as the dimensions of quality.

The data here are primarily on hospitals and ambulatory care so inpatient and ambulatory care. However in the chapter we will be presenting more information than just this information on hospitals and on physicians. For example, we'll be including the QIO data that CMS has collected on clinical effectiveness through the process

measures that they collect. And we'll also be hopefully presenting upon the data, we're having some data issues with our ACE-PRO analysis, that looked at the provision of clinically necessary services in the ambulatory setting.

We will also be including in the March chapter on quality, some information on quality and home health agencies, skilled nursing facilities, dialysis facilities, and Medicare+Choice plans.

These data are useful to the Commission for several reasons. First of all, it helps us examine care in specific settings. But I think, as the discussion showed yesterday, there's a lot of interest in how we might go forward and continue to find ways to put in place incentives in various settings to improve quality. So it also gives us some sense of what settings might be most important to target, as well as the types of quality problems within those settings that would be important for any incentives program to actually focus on.

The third reason that we feel this information is useful to the Commission is that we have in our quality agenda wanting to explore the relationship in various settings between the cost of care and the quality of care to

really look if there is a relationship or not or what that relationship looks like. As you may recall, we did that last June in the dialysis facilities and we were hoping to also explore that in home health and SNF for this June report. So this gives us also some indicators that we could use for that project.

So let's go ahead.

First of all, what are the indicators we're going to look at? Before we go any further on what they actually are, I think it's important to note that it really would not be possible to be presenting these data or to be looking at administrative data in this way without the leadership of John Eisenberg and then continued with Carolyn Clancy at the Agency for Health Care Research and Quality. I think it's important to note that all four of these indicator sets were developed by AHRQ over a period of several years and they have now become very useful for applying them to the Medicare program.

The first three data sets provide information on mortality by condition and procedure, patient safety, and potentially avoidable admissions. They were designed to run on administrative data, first of all by AHRQ to run on their

dataset, which is the Health Care Cost and Utilization Project data, which is hospital discharge data that's reported to the states. I think they have about 30 states in their database now.

But the folks that developed these sets were also instructed to make sure that the indicators were able to run on any type of administrative dataset, so that it would be possible for people like ourselves to take this and also run it on Medicare claims. Which is what we did.

The claims that we ran them on was the MedPAR file, which is the hospital discharge file. We ran it on 100 percent of all claims in the hospital file because many of the patient safety indicators are very small. There's a very small rate and so it was really important for us to be able to actually get a larger sample for those. So we ran everything that we did then on the 100 percent if MedPAR.

We did exclude some of the indicators that were not relevant to Medicare, such as those that applied to pediatric care. And then a very few of them we found when we ran the data had very low occurrence. And so we don't present the data for those here. So those are the difference between what we did and what AHRQ did, in terms

of the actual indicators we included.

I also wanted to note, particularly on the first two, the mortality and the patient safety indicators, that these are, of course, a different data source then you'll find in the QIO data. The QIO data are based on medical record abstractions. So usually you have smaller samples, they're harder to collect. But as Nick points out, in fact, possibly provide a little bit more direct information to hospitals on what they might do to actually improve on those indicators. But they are somewhat different and I just want people to keep that in mind as we go through our discussion as what you might do with these indicators and these data that we have.

MR. DURENBERGER: [off microphone.] Karen, could you explain that, the importance of that?

MS. MILGATE: The importance of the distinction, I guess, is I assume people will use some of these indicators to say well, hospitals should maybe report this or would we base an incentives initiative on these data or that data. And I just want it to be clear that the data that we ran, basically you can collect separate from requiring the hospital to do anything, because it's simply a part of their

claims process to get paid, that they report information that is coded in the ICD codes.

And then what AHRQ did was take various ways of putting those codes together to say patients that were coded this way should be excluded. And that they develop their mortality rates. So someone else can actually extract the data, read it, and see how useful it is.

The QIO data is, in some ways, for quality measurement -- I don't know if I want to use the term more precise. But it's things like did you give a beta blocker when you should have, hospital? So they are, in some ways, a step up in that they aren't indicators that a problem could be there. They actually are measures of something that should have happened. So they give the hospital the ability to change something more directly. But they still both measure problems. They're harder to collect because the hospital has to go into the record or somebody and find those things. So it's just much more burdensome but provides probably more precise information.

The fourth set here is a survey which we spoke about at the October meeting and also Cristina talked about in her presentation on physician access yesterday. And

that's the CAHPS survey, the Consumer Assessment of Health Plans Survey. This was originally developed by AHRQ for private plans and then revised so that it could then be applied to Medicare+Choice plans, and then revised again so it could be applied to Medicare fee-for-service.

So what this gives us, because it's such a large survey, so it's between 100,000 and 120,000 beneficiaries are surveyed every year, at least they have been for the last three, is some pretty good information on how beneficiaries perceive their access and quality of care. So we presented some information on access at the October meeting, and here we'll be presenting some information from the questions that relate more directly to quality in this meeting.

You see before you the team of folks that have looked at these data. So each of us will report on a particular indicator set. Sharon?

MS. CHENG: The first set of indicators that we have here this morning are for inpatient quality. Inpatient hospitals are certainly an important setting in which to measure quality. They provide about 10 million hospitalizations to Medicare beneficiaries annually.

This set of indicators reflects the quality of inpatient hospital care by measuring the rate of death among beneficiaries in the hospital and 30 days from admission to the hospital. The indicators on the screen here are ordered by the number of in-hospital deaths, which is shown in the last column.

We measured it two ways, in-hospital and 30 day. The in-hospital mortality is perhaps more directly attributable to the hospital because it's all within the hospital setting. The 30-day rate could indeed be influenced by the quality of settings that a beneficiary uses after a hospitalization, especially post-acute care providers. But it's also a useful way to look at mortality because it's going to be less affected by the discharge patterns of the hospitals, whether there's a short or long stay for that beneficiary, determining whether they would experience mortality 30 days after the admission in the hospital or whether they were discharged and experienced it outside the hospital.

MR. HACKBARTH: Sharon, could you remind us why these? Why this list of eight, as opposed to some other list of eight?

MS. CHENG: AHRQ chose these particular types of mortality because of the evidence that they could gather for these mortality. They're a little bit of a mix. The top of the list are conditions. The bottom of the list are actual procedures.

For each one of these there was a bulk of evidence that showed that the rate of mortality did vary with some aspect of the hospital. In general, that aspect was volume. Higher volume hospitals with similar patients had a lower rate of mortality. But also, especially for some of the procedures, there was evidence that linked the procedures in the hospital to the rate of mortality for similar patients. I'm going to talk about that a little bit more in the next slide.

MR. HACKBARTH: And these represent what percentage of Medicare admissions?

MS. CHENG: I have to get back to you with the number. They're pretty common admissions so it's a large portion of hospitalizations.

The rates of mortality here are risk adjusted by age, sex, and the severity of the patient's condition using the APR-DRG measure of severity.

In summary, the in-hospital mortality rates improved across the board from 1995 to 2000, which is to say that the rate of mortality dropped for each indicator that we measured. The most substantial improvements occurred for CHF and for GI hemorrhage.

The 30 day mortality also improved for every indicator except two: pneumonia, which was the most common precedent of mortality among those that we measured and for craniotomy.

Patients with the same condition or procedure die outside the hospital more frequently than in the hospital. The greatest difference between the in-hospital rate and the 30 day rate occurred for patients with CHF. There were two exceptions to this pattern, for AAA repair, which is abdominal aortic aneurysm and for CABG.

The trend in these mortality rates from 2000 to 2002 is the same trend as from 1995 to 2002 for in-hospital mortality. However, all but one of the 30 day mortality rates increased from 2000 to 2002, the opposite of the longer-term trend.

As we suggested, they chose these mortality rates because of the evidence that was behind them. In most cases

that was volume. In some cases that was a procedure. For example, evidence showed that surgical teams that could reduce the time to cross-clamping the aorta during a CABG procedure reduced the mortality for similar patients. For teams that used an epidural anesthesia instead of a general anesthesia during hip replacements could also reduce mortality among their patients.

So to the extent that mortality indicators reflect the clinical effectiveness of hospitals, we can conclude that quality has risen from 1995 to 2002.

Next, David and Karen will present evidence that while quality in terms of clinical effectiveness appears to be rising, quality in terms of patient safety or the quality of ambulatory care that could prevent hospitalizations seems to be moving in the opposite direction.

DR. REISCHAUER: Just a clarification, the pneumonia category there, there are just people who have been admitted to a hospital with pneumonia, as opposed to all of the Medicare patients?

MS. CHENG: That's right.

DR. REISCHAUER: So in that case, obviously not for some of the others, you can have changes in behavior for

admission for this diagnosis?

MR. HACKBARTH: [off microphone.] Sicker patients are being admitted.

MS. CHENG: Right, although to try to capture some of the effect that a changing population could have, that's why we did try to risk adjust -- we used 2000 as the base year and then we kept the age, sex, and APR-DRG of the patients constant. So to the extent that that was successful, we're seeing a real trend and a change.

MR. GLASS: Now looking at the patient safety indicators we see a different story. This slide shows eight of the 13 patient safety indicators we analyzed for hospitals with Medicare discharges. Again, they're ordered by the number of observed adverse events in 2000.

It shows the change in the risk adjusted rate from 1995 to 2002. The changes in the rate of adverse events per 10,000 eligible discharges, and for each indicator those eligible only include certain discharges that were at risk for the adverse event.

Further, some discharges were excluded to be sure that the complication observed was a result of what happened in the hospital and wasn't present at admission. For

example, decubitus ulcers only include stays of over five days and exclude admissions from other institutions for patients with a paralysis. So these, again, were developed by AHRQ and they've tried to isolate what was going on to be what was happening in the hospital.

As you can see, the rate for seven of the eight indicators increased from 1995 to 2002. Overall, nine of the 13 indicators showed increases and four showed decreases, as the table that is in your mailing materials shows in detail.

The four indicators with decreasing rates include the two resulting in death, failure to rescue which is second there and death and low mortality DRGs, which isn't shown. That occurred about 3000 times. This accords with the decline in mortality, especially in-hospital mortality that Sharon discussed.

So while it's evident the rate for most of these indicators has increased, we cannot say why. Although we've risk adjusted these numbers by age and sex and comorbidities, it is possible that severity has increased for the population considered for each indicator. So we didn't do the APR-DRG risk adjustment on these because that

would have interfered with what they were actually trying to look at, which was complications resulting from the primary diagnosis.

Most of the rates are relatively rare events with rates under 100 events in 10,000 discharges. So one way of looking at that is that post-operative sepsis, if you have 7000 events in 2000 and say you look at 3000 hospitals excluding the smaller ones, that's only two or three per hospital if they were evenly distributed. So these are rare events and that might affect how we want to use this going forward.

The pattern of increases and decreases, the same looking at the changes from 2000 to 2002 as it was from 1995 to 2002. So it's not a passing phase.

Now Karen will look at the next set.

MS. MILGATE: What you see in front of you here switches gears a little bit. While it uses hospital discharge data to create these indicators, this is really an indicator of the quality of care, or it is trying to be an indicator of the quality of care of ambulatory care. So this looks at the outcomes of poor ambulatory care by looking at admissions to the hospital that could possibly

have been avoided.

These are conditions for which evidence suggests optimal ambulatory care could have prevented, at least in part, some of these admissions.

Now it's important to note that it's really hard to assign accountability for poor ambulatory care because there are so many different factors that affect the type of care that patients get outside of the hospital. This could be due, for example, to access to appropriate ambulatory care. It could be that patients are actually getting into see physicians but then not getting the appropriate care management. As we know, there are also some lifestyle issues with how, for example, weight gain or smoking could affect a patient's admission to a hospital.

In addition, there are two of these, chronic obstructive pulmonary disease and diabetes, that the prevalence has increased over the last few years. So the prevalence increase could also increase these numbers.

Having given those caveats, what we see her is that of the eight that are shown here five of them did increase fairly significantly between 1995 and 2002. The good news we see, however, is the top one, congestive heart

failure, which basically was responsible for 703,000 Medicare beneficiaries being admitted to the hospital in 2000 has gone down just slightly. It had a 1.0 decrease over that period of time, perhaps due to a better quality provision of ambulatory care. Some of the new evidence that ace inhibitors and beta blockers are effective at preventing admissions for this type of condition, it looks like at least that patients are getting those types of drugs potentially.

The top five here, just to note, I guess you can read the slide, are congestive heart failure, pneumonia, COPD, urinary infection, and dehydration.

So this indicates that there are some issues with, again, the quality of ambulatory care. And I think it's interesting, I wanted to stop at this point to say something about how what we see here relates to some of the legislative changes. I don't know that the congressional staff were looking at a slide like this, but you can see with their emphasis in the bill on chronic illness management that those are the kinds of programs that could perhaps target some of these conditions, to provide better quality care to patients in the ambulatory setting. For

example, if they targeted diabetes, COPD, and CHF, which are often talked about as the good targets for disease management, rates could go down on these admissions.

MS. RAPHAEL: For these, did these people have an encounter in the ambulatory system?

MS. MILGATE: We don't know. We could probably link some datasets and find out. What we see here are just their admissions, so it's a pretty basic number of what were you admitted for. So we don't know their ambulatory history.

MR. HACKBARTH: So this is the total number of admissions. We're just looking at the total number of admissions for CHF, is it going up or is it going down?

MS. MILGATE: That's right.

MR. HACKBARTH: This is, in any sense, a subset of CHF.

MS. MILGATE: That's right.

MS. BURKE: I actually was tracking similarly to Carol. Given our discussion about home care, as well as ambulatory care generally, is there anyway to track by matching datasets to what extent we've either seen an increase or a decrease in the treatment for these conditions

in the obligatory setting? For example, with respect to home care, is there a way to track whether or not we've seen an uptick or relatively stable number of patients with any of these conditions being treated in a home care setting? The obvious ones are things like dehydration, urinary tract infection, as well as the usual pneumonia and so forth.

But it would be interesting to see whether we're seeing a change in behavior in terms of either no care or traditional care, which is less effective, whether the interventions have altered.

MS. MILGATE: I'm not sure about the home health example but there certainly are ways to link, through using the beneficiary ID, folks that had admissions as well as how much care. And possibly, through our ACE-PROs, even look at clinically necessary care.

MS. BURKE: You mean whether these were people that were essentially being transferred out of nursing homes. It would be interesting to see whether there is a pattern there, in terms of whether they're being treated or not and whether they're essentially coming out of a setting where they should have anticipated these but did not

MS. MILGATE: So we can look at admissions and

source of admission, for example. Yes.

MR. HACKBARTH: It may even be --

MS. MILGATE: Well no, I don't know if it's possible by January but certainly is something we could follow up on. And just a note on urinary infection and dehydration, given they are in the top five, it also tells us there may be some important focus there, right?

MS. BURKE: Right. The sourcing of where they came from, I think, could make a critical difference in terms of our understanding of how they're being treated, whether they're being transferred on. And watching these patterns generally, in terms of encounters, where they're coming from.

MR. HACKBARTH: This is also an interesting time period in that it spans some important changes in payment systems for -- it may even be interesting to look at different time periods within this seven year window.

DR. NELSON: That's one set of issues on how to make the data more precise. But there's a more fundamental issuance and that is the use of administrative data which were submitted for a different purpose. They were submitted to get a claim paid. And trying to interpret those data

when the reporting is the real issue, not the occurrence of the events. It's whether the were reported or not. And particularly with the patient safety data, extrapolating 95 numbers to now or 2000 and trying to draw any conclusion when, as a matter of fact, one of the impacts of the IOM patient safety report would be to increase the amount of reporting.

I mean what the IOM said is that the first accomplishment will be if we have errors reported. Henry Krakauer got the IOM going on a series of studies in 1990 and whether or not -- how the Medicare claims database could be used to draw some conclusions about quality. Ken Shine chaired those committees. I was on them.

And the bottom line was that most of our recommendations called for the PROs to go to the blood records because that was the only way you could really be certain that you were getting accurate data.

The use of claims data becomes particularly problematic when you're looking at indicators that are largely subjective such as dehydration. Note that the data are much more aligned if you're looking at a clear objective event like amputation. But is a patient dehydrated or not?

If it's reported, is the reporting because they may get more payment if they have a comorbidity including dehydration?

I think any of the indicators that are subjective, in terms of A, being identified; and then B, being reported, should be interpreted with more caution.

I'd be reluctant to publish these data at all because of the uncertainty about the accuracy. Even the IOM patient safety studies were challenged and they involved duplicative chart audits.

MS. BURKE: But wouldn't that be more a case -- I mean, I appreciate what you're saying and there are certainly cases where it could be interpreted in different ways. But it would seem to me that presenting conditions, pneumonia, COPD, urinary tract infections, to what extent are there likely to be errors in judgment about whether or not they were present or not? I mean, dehydration is a variable, but I don't know how you would misrepresent whether someone had a presentation of pneumonia.

DR. NELSON: I guess I'd like to have my comment separated in terms of the mortality reports within the hospital, which I think are pretty good, pretty clear cut.

MS. BURKE: Straightforward, right.

DR. NELSON: And the ambulatory indicators, when you don't have any way to go to the chart and verify what was there, and drawing conclusions. Urinary tract infection, what's a urinary tract infection? Is that cystitis, or is that acute pyelonephritis with something really severe?

I guess if we do report this, I'd sure want to have a lot of caveats in there, for the reasons I've said.

DR. REISCHAUER: Can I comments on this, because I think Alan's concerns are particularly relevant if we were using this kind of information to say Utah does a better job then Minnesota or this group of hospital does a better job then that group of hospitals.

But when you're looking across time at the nation as a whole, these inaccuracies exist. There's no question about them. But the real issue is do they vary tremendously from year to year? And when you see a reduction in one of these measures of 49 percent over a five-year period or something like that, I think you can say with pretty good confidence things are getting better.

When you see them about constant, you don't know. But I mean, I think the purpose of this really is to get a

broad picture of changes in quality of care for Medicare over the nation and say something sensible about that. I think you're right to look at these numbers and say don't place a bet on the actual number.

DR. NELSON: Let me respond to Bob, because I think this a critical point. And the thing that triggered my response is that we have been saying, yesterday and today, that these data show that quality is getting worse. It may be. I'm a firm believer in the quality chasm. I'm not apologizing for the quality of care out there.

What I'm saying is that it's hazardous to use these data and infer that quality is getting worse because it may be just that the reporting is getting better. That's all I'm saying.

MR. MULLER: Along those themes, part of what puzzles me about this information is that this is a period in which, by and large, admissions per thousand, any kind of numerator, were going down across the board, because there were less admissions per thousand, whether one attributes that to managed care or movement towards outpatient setting, better anesthesia and so forth, but it was a period in which admissions in general were going down. So it's kind of

puzzling to me that they would go up on these conditions. That's one point I'd like to have you comment on.

MS. MILGATE: These are rates.

MR. MULLER: But I'm saying the rates were going down. The rates of hospital admissions were going down in this period.

MR. GLASS: These are rates per 10,000 admissions.

DR. REISCHAUER: [off microphone.] But these are rates of an event or incident.

MR. HACKBARTH: Per 10,000 admissions.

MR. MULLER: But if the rates per 10,000 were going down, why would the rates in general --

MR. HACKBARTH: So if it went down at the same rate as admissions in general, it would be a zero. So if it's going down faster than admissions -- isn't it?

DR. REISCHAUER: [off microphone.] No, it wouldn't.

MS. MILGATE: No, it's just how ever many people were admitted, whether it's a higher number or a lower number. It's just a rate of those that were admitted.

DR. REISCHAUER: [off microphone.] The argument we would make is that as admissions go down, the severity of

the average admission goes up but they're making some kind of adjustment for that, so we don't necessarily have to worry about that. So I don't think there's a problem.

MR. MULLER: Wait, we're making an age/sex adjustment, right?

MS. MILGATE: These ones? These are age/sex, yes. They're all risk adjusted by different mechanisms so that's why we have to be careful about that.

MR. HACKBARTH: Could I get you, Karen, to respond to the issue that Alan has raised? In particular, his concluding point, which I think was a nice concise summary. These are going up because we're looking at them and encouraging people to identify problems.

MS. MILGATE: Just a couple of points on that. Alan's point, I think, are particularly important when we looked at the patient safety indicators because I think that's where if you were going to think that hospitals were focusing on a problem that was of high public importance, that's where it would come in. I think that's also the area where the fact that we're relying on administrative data may have more import than the other two indicator sets.

A couple of points there. As we discussed the

caveats that were necessarily when thinking about using administrative data, one is that I think that Alan's point is very valid if we were talking about any kind of public reported on safety events. I think it would be clear that we would hope and even expect those rates to go up.

I feel like it would be less the case if you're talking about simply looking at data that were presented for payment of claims essentially, that hospitals would then code more of these events simply because there was more focus on it.

On the other hand, I think there are some other issues with what was going on in coding during those years. One is there was a lot of emphasis on enforcement of fraud and abuse statutes, for example. And so one thing we had thought is perhaps coding became more precise and so these events went up. But on the other hand, there was also sort of a backlash against any kind of upcoding. And these are going to be the coding of the more complicated procedures.

So I guess I see there's various forces that would be at play there.

The other thing though to check to make sure that we were the right numbers, we did look at and compare our

rates to what AHRQ had pulled together on their HCUP database, which is all payer. And then, in fact, CMS has also run these indicators on a Medicare population, a little bit different analysis but not that much, and found that our were very similar in magnitude.

Now the HCUP was the all payer, so their rates were somewhat lower. But looking at the trends over time, they went the same direction, up and down. And it was the same thing when we looked at the Medicare data. So it made us feel pretty comfortable at least that everyone was measuring the same way.

And in terms of whether we're using administrative data, I guess like we felt like we had some pushes and pulls that led us to feel pretty comfortable with the data.

MR. MULLER: I want to go to my public arithmetic here with Bob, because if the rate of admission goes down, which I think is what happened during this period, the overall rate went down, and these rates go up, that's kind of puzzling to me, as to why would the overall rate of admission go down and these ambulatory care sorts of admissions go up. So that's why I'm asking it.

If rates are going down of admission, which

implies something is going on, whether it's anesthesia or more outpatient care and so forth, yet the rates for these conditions go up, that's a counter movement. So the question is why would you hypothesize they would go up on --

MR. GLASS: This isn't the rate per population. This is the rate per admission. So we're saying the rate of people with CHF --

DR. REISCHAUER: [off microphone.] Who enter the hospital.

MR. GLASS: It's not the number over the general population. It's the number over the number of total hospital admissions.

MR. MULLER: So this is the proportion of hospital admissions to which -- okay. That's why I want to do math in public.

MS. MILGATE: It does appeared though that these are perhaps a larger percentage of the admissions, even though the admissions have gone down.

MR. MULLER: That's what's puzzling to me because you just said we're not tying this to any ambulatory dataset. So it's just --

MS. MILGATE: Hospital admissions, number of.

It's pretty basic, in terms of that. Yes.

MR. MULLER: What's puzzling to me is it's a period in which even prior to the IOM report that Alan referenced, looking at these kind of quality indicators goes back 10 or 12 years and the Joint Commission started pushing this in the late '80s or early '90s.

So to hypothesize at a time when people were pushing more to improve quality of care and unevenly, as certainly the IOM reported indicated, and as Alan said. Nobody wants to be an apologist for what the level of care is. But it's puzzling to me at a time when people are focusing on improving care, that the rate of poorer care would go up. It's counterintuitive. So in some sense, the more you push for quality, the worse the outcome?

MS. BURKE: But Ralph, let's think individually. Pneumonia could well have been flu. You could see, over the less couple of years, an uptick -- I mean, it would depend on what kind of pneumonia it was. In the case of UTIs or dehydration, it could well be the treatment they were getting in a nursing home. These may not be the fault of a hospital. These may be presented in a hospital setting because of the absence of sufficient care in advance of the

admission.

So these are potentially avoidable. It doesn't mean that the hospital has given poor care. It may be that the poor care occurred before they ever got to the hospital.

MR. MULLER: I understand that and I think they qualified that fairly well. My point is it would be surprising to me to say that the health system in general was having more admissions for avoidable conditions at a time they were trying to focus very imperfectly --

MS. BURKE: [off microphone.] The focus was more on the hospital side than it was on the nursing home.

MS. MILGATE: We did see the decrease in mortality. The news is not all bad. I think there was some focus from hospitals and physicians that led to that decrease. It may be that that's an easier problem to focus on. I don't know. But we did see some improvement. And the QIO indicators, as well, the process measures that they look at, did improvement. They improved on 20 out of 22 of them, as David reported. So it's not all a bad news story.

MR. HACKBARTH: And CHF and asthma certainly were two areas of major focus for the ambulatory and they both got better.

DR. NELSON: This list of potentially avoidable admissions, it makes a darn good case for not reducing payments for home care and long-term care for those who subscribe to that theory, that a lot of these -- these are the conditions of people who have run out of gas.

MS. BURKE: [off microphone.] That's my point is trying to understand where the admission is coming from. You can track it back to an ambulatory setting or to an inpatient skilled nursing facility.

MS. MILGATE: Should we move on?

MR. HACKBARTH: Yes.

MS. MILGATE: We have one last indicator set to present information on. Sarah will present that.

MS. LOWERY: Now we'll look at CAHPS data for Medicare fee-for-service beneficiaries in years 2000 through 2002. As you can see, overall beneficiaries highly rate the health care they've received and the quality of their interactions with their doctors and health care providers. On a scale of one to 10, 10 being the highest, over 80 percent of beneficiaries gave a rating of eight or higher to their personal doctor or nurse, the specialist that they saw most often in the last six months, and all the health care

they had gotten in the last six months.

They also highly rate the quality of interactions with their doctor or other health care provider. For example, between 93 and 95 percent of beneficiaries reported that their doctors or other health care providers usually or always listen carefully to them, explain things in a way that they could understand, and showed respect for what they had to day.

Beneficiaries seem slightly less satisfied with the amount of time spent with them, but still over 90 percent are satisfied with this aspect of their health care.

In contrast to these results, we see mixed outcomes when looking at beneficiaries' preventive care and habits. A consistently low percentage of beneficiaries received a flu shot in any of the three years or had ever received a pneumonia shot.

However, data on smoking improved over the three years, as you can see. The number of beneficiaries that had been advised to quit smoking by their doctor or other health care provider on at least one visit in the last six months rose substantially over the three years.

As you will note in lines four and five, data was

not available in a couple of 12 years. This essentially means that the questions asked in all three years are not simply comparable. For example, the question of whether beneficiaries smoked was asked of all beneficiaries in 2000, resulting in a smaller number of smokers than in 2000 and 2001, when the question was just asked of those beneficiaries who had smoked at least 100 cigarettes during their life.

Finally, of the beneficiaries who were physically able to exercise, this is about 83 percent of beneficiaries since over 16 percent cannot exercise due to their health. So of the 83 percent of beneficiaries who can physically exercise, about half exercise for more than 20 minutes at least three times a week.

MS. MILGATE: So what we see here, in summary, is that some indicators are proving, others are worsening. We saw that mortality is improving. It's decreasing as a rate for inpatient mortality, both inpatient measured in the hospital as well as 30 days from admission. We do see, although, some increase in adverse events in inpatient care and some increase in potentially avoidable admissions.

However, beneficiaries are very satisfied with the

quality of care they are receiving.

These data provide useful informational on the quality of inpatient ambulatory care and perhaps suggest some ways that we might be able to think about targeting incentives in the Medicare program. I think we had a pretty good discussion on what we might be able to look at in the ambulatory setting, but it also seems to suggest that for hospitals it might be important to look more closely at patient safety in addition to the type of information that can gathered from the current quality inpatient reporting initiative.

At this time, we'd be interested in your comments, in addition to what you've already commented on the data, and questions about the data, as well as what you think these data tell us about Commission work on quality.

MS. ROSENBLATT: I think this is a very good introduction to this whole subject and it's nice to finally have some numbers connected with it.

I have one question on the stuff from the CAHPS survey. Is there a way to compare the members that we're getting on the Medicare beneficiaries with an under-65 population? This isn't very scientific, but my experience

in talking to people over 65 is that they're much more willing to view the physician as godlike and it would seem to me that you'd tend to get higher ratings from those over 65 data than under 65. That's just my own personal opinion.

MS. MILGATE: On these actual questions, I don't know. I've ever seen a survey that has this much detailed questioning of those under 65. There is the National Health Interview Survey which does interview all ages and we do see on that survey consistently that Medicare beneficiaries report much fewer access problems, at least.

I'm not aware of a dataset that goes into this much detail on quality.

MS. THOMAS: Joe was just telling me that AHRQ put a warehouse together of private plan members reports on their experiences. So we could definitely take a look at that.

MS. MILGATE: I'm sorry, it was developed for private sector, excuse me. That's true, we could look at that.

MR. HACKBARTH: At Harvard Community Health Plan that was our experience and we had sort of a controlled system so we could look at seniors and younger people in the

same clinic, seeing the same physician staff, experiencing the same system of care, and the seniors are consistently rated higher.

DR. REISCHAUER: It strikes me that this is an important issue to gather information on. It is conceivable that younger people don't get as good service, but it's also conceivable that their view of authority figures is different. And so what we're going to see over the next 30 years is more skeptical people coming into Medicare and these ratings going down. And you don't want to get all worked up thinking that something is changing when it isn't changing.

MS. ROSENBLATT: It's also the issue, Bob, I'm hearing from a lot of physicians that the younger patients come in with Internet data and lots of questions and the over-65 population, particularly those over 85, are not doing that.

MR. SMITH: As a close cousin of love Durenberger, hate the Senate, I'd be very careful with 93 percent satisfaction rates drawing much of a conclusion from that. It's better than 50, but I wouldn't walk out very far on the road with the CAHPS data.

MS. DePARLE: I was just going to say, I know that we did, even three or four years ago, have this kind of ability to compare with some private plan datasets and the phenomenon you're mentioning did seem to be there.

In addition, what I remember was that on at least one of them we had the ability to parse between 65 to 70 and then 80 to 90. And the older you get, the more appreciative -- I'm speculating, but it seemed the happier you were and perhaps the more appreciative you are of what you're getting or, as you put it, respectful of authority figures, whoever said that.

DR. REISCHAUER: Or maybe those that are satisfied get better treatment so they stay alive.

MS. DePARLE: There is some recent data on that actually, that the more satisfied your are the longer you live, the happiness. So hey, I'm there.

MS. BURKE: Two questions. One, are you able to separate out the satisfaction with physicians as compared to nurses?

MS. MILGATE: They actually asked that question together because they ask if you have a personal or nurse, and then they don't -- actually, they probably could because

they do say whether they have a doctor or a nurse.

It's a small percentage that say nurse as their primary, but yes, I think we could probably separate that out.

MS. BURKE: And the second question, and that this may only be true of pediatrics and I suspect Nancy-Ann has experienced this, as have I. Routinely now, in the series of questions -- and what struck me was the questions about smoking and habits.

In the series of questions that are now asked of parents with young children is a question of whether there is a gun in the home. And this is something that is increasing being tracked.

I wondered whether -- I mean, it may be an age issue because of the incidence of gunshots in the younger population, but it's actually seen as a preventive issue and intervention. And I wondered whether that was being tracked with an older population or not. It may not be because it may not matter as dramatically, but it is now present in every interview with every pediatrician that I've had any experience with in the last couple of years.

I didn't know whether this was true for adults,

but it may not be.

MS. MILGATE: Not that I know of, but I haven't asked the question.

MS. BURKE: It may not be. I suspect it's more peds.

MS. DePARLE: We would have been afraid to ask that kind of question, for reasons you can imagine. Because I know on OASIS one of the criticisms was -- Carol will remember this -- we asked about -- and I went through every question after all the controversy over this -- whether there was another person in the home, which is relevant, you clinicians will understand that, for whether there's another caregiver around. That makes a difference in their status.

But some people thought we were trying to find --

MS. BURKE: Find out what their personal lives were.

MS. DePARLE: Yes, you have to be careful about that.

DR. NELSON: I think this obviously is an important subject for a chapter. And I think that it ought to include our findings from the administrative database properly qualified.

But I think also it ought to include information, if we're trying to set the stage to draw some conclusions for longitudinal assessment of quality, quality assessment over time, then it should include also the findings from the Joint Commission and what they are determining based on their requirements for accreditation.

And with particular emphasis on whether things are stable, getting better, or getting worse, where the accomplishments are, where there appears to be areas that still represent substantial deviations from expected quality. Then we can consider this in the context of our job in terms of payment recommendations.

But I would think probably NCQA ought to be referenced as well, so that we have a much broader set of data to hang our hat on than just what we've been able to glean from the administrative datasets. And the PROs, obviously the QIOs.

DR. WOLTER: Similarly, I was just going to say, along the same lines, I actually think this is quite excellent. And with the caveats that have been brought up, I think it will be quite a contribution to put this together along with some of the other things you mentioned that will

be coming forward, the QIO, JCH, some of those other things, because we're still at the beginning of something here.

And as we look at this data, the obviously occurs, which is people ask questions. And then they ask questions about how to make the data better. And then that leads to how do we create change? So this will be a great contribution, I think, for MedPAC if we put this information together in one place as others outside of health care begin to look at it.

One specific question. Can we cut this by Medicare+Choice fee-for-service and look at those populations separately?

MS. MILGATE: The only one -- we could do the CAHPS that way.

DR. WOLTER: I meant more specifically.

MS. MILGATE: We don't have claims, unfortunately. I guess the comparisons that possibly could be made would be not on these data but looking at some of the fee-for-service rates from the QIO program and some similar measures on HEDIS. So it might be possible to look at those and compare those.

DR. WOLTER: It would be nice to think going

forward about how we might try to do that, since if we're going to put any quality incentives in place for plans, we might want to have some way to look at that vis-a-vis the things that are being done in the fee-for-service sectors, so there might be some comparability. That might have to be designed going forward.

MS. ROSENBLATT: On that issue, wouldn't we have inpatient data from PIP-DCG stuff, and we could at least look at those unavoidable admissions things?

MR. GLASS: I don't know if you have complete claims data. It's abbreviated.

MS. THOMAS: We can certainly investigate it. You certainly wouldn't have the time trend over those seven years, but we could certainly explore that data.

MS. ROSENBLATT: Part of it. When did the PIP-DCG go in, Scott?

MS. THOMAS: There was a run up to -- we can explore it.

MR. HACKBARTH: Good idea. We'll see what we can do.

MS. RAPHAEL: I just was curious if you have any hypotheses. I was struck by your last chart on preventive

care. We do flu vaccines in our region and actually the rate of flu vaccines for minority populations is in the 30 percent. We've been trying to get that up. But that hasn't moved and the pneumonia vaccine has moved minimally. And yet we saw an increase in admissions for pneumonia.

And I'm wondering if you have any hypothesis about why we have not been able to change that.

MS. MILGATE: I'd digging back into memories with talking to QIOs about how difficult it is to get pneumonia shot rates up. I don't know, Alan might be better than answering that than I. I don't know. The flu vaccine rate has gone up some, although you see these data here, not on the screen currently. But the CAHPS data don't show it going up as much as the QIO data. So that was kind of curious to me.

It may be because beneficiaries are not -- I don't know, you'd think they'd be aware. I don't know. I should just say I don't really know the reason. Alan, do you have any ideas about that?

DR. NELSON: I'd have to ask what's happened to the payment rate and whether the is adequate. I don't know the answer to that. In the past it was said not to be but I

don't know how much it's been improved.

MS. MILGATE: And I know that in the QIO program they had issues because their primary focus was on hospitals and then, of course, there's some reticence to give these types of vaccines within the hospital setting but other than that I don't really know. And I don't know what the payment rates are, either.

DR. NELSON: I think they were -- and I should know, but I've forgotten. Last year it cost the physician money for every flu shot they gave. And you can't make that up in bulk volume. I think, as with so many of these preventive services, if you want to have good counseling you have to pay for good counseling. If you want immunizations and preventive services, you can only rely on good intentions up to a certain point. And if they're losing money with it, it's not going to meet the standard we'd like.

MR. DURENBERGER: This is probably not so much a clarification as for the final chapter, because I came early and got answers to a bunch of my questions. One of them is the question is what else can be measured by administrative data that we may not have already measured and/or this

indication it is impossible to measure adverse events that may have been due to medication errors using administrative data.

There's a whole area, it seems -- and I think about the Wall Street Journal article of a week ago as one example. I think about the fact that hospitals get paid to make mistakes and they get paid again several times to correct it, if it takes a couple of times to do it.

There's probably a whole body, both in the area of safety and of quality, that can't be accurately measured on administrative data. And it would be helpful if we would not try to answer the question as much as clarify the potential for problems that could exist in this area because they've been reported anecdotally or they're reported in some other context so that the larger picture is demonstrated.

And then I think my second observation is relative to the way in which we present the CAHPS information because I read it to say that people think they're getting good quality after we've told them it's not all that great, in effect. And so if it's perception, then I think we ought to highlight perception. That people's perception of quality

is sort of a relational perception.

I can always see my doctor. I have confidence in my nurse, or in whatever it is. As opposed to something else because it is not the perception that I experience in my work in Minnesota. The folks with whom I work do not find the system that satisfactory.

So it's clarifying why we're using that survey data in this chapter that I think is important.

MR. HACKBARTH: I think there's also evidence to support the fact that people do distinguish between their doctor and the system. They'll say I like my physician, I have a good relationship. But then if you ask them about the system as a whole, they'll say it stinks. I don't think the two are necessarily inconsistent.

Ray, and then we need to move ahead.

DR. STOWERS: I'm just going to make a comment on that QIO. Dale Brassard just wrote some recent articles, too, on the distribution of the vaccines. And he's saying that the percentage out there seems to be consistent with the percentage of the patients that are making it through the physician's offices. So that they're not doing that bad of immunizing.

So they're saying that we need to broaden the distribution system. So whether it be the health departments or the pharmacies or of the grocery stores or whatever, we've just got to get more exposure to the beneficiaries out there as a place that they can get them while they're out there. Home health care, nursing homes, that kind of thing, that maybe we're limiting the sites where they're giving them more than anything.

DR. NELSON: To end up with sort of the good news finding of the meeting. Last meeting, Jack Rowe pointed out it was the marked reduction in admission for stroke, was really the sort of good news surprise.

This one, my good news surprise was the reduction of smoking on the last page where it dropped from 24 to 12 percent in one year of patients surveyed who said that they smoked cigarettes every day, some days, or not at all.

MS. MILGATE: Not to burst your bubble on that being the good news, but in fact those first two years were asked differently than the last, which we discovered just in the last couple of days. And so that's why it's still in your materials.

But first years they basically said have you

smoked in the past? And then the question was asked of those. So that percentage is probably higher because they smoked in the past.

But the last year is of all beneficiaries and the rate is -- I don't know if I could characterize it as low. But it's 12 percent or so. But the doctors advising people to not smoke did go up. That was what I thought you would say the good news was. I thought that was pretty good.

DR. NELSON: That's good news.

MR. HACKBARTH: Okay, thank you very much. Good work.

Next up is ambulatory surgical centers.

MR. WINTER: Good morning.

I'll be discussing our assessments of payment adequacy for ASC services and our draft recommendation for updating payment rates for 2005.

I'll also be discussing ways to revise the ASC payment system AND how CMS decides what procedures to pay for in an ASC.

We'll start with the question of whether Medicare payments for ASC services are adequate in 2004. In assessing payment adequacy, one of the factors we generally

look it is the relationship of payments to costs. As we've discussed before, however, we lack recent data on the cost of ASC services. CMS was required by statute to perform a survey of ASC costs and charges every five years but it's last survey of ASC costs was in 1994. The Medicare conference agreement eliminated the survey requirement.

We'll come back to this issue later on, when we discuss how to revise the ASC payment system.

So to assessment payment adequacy ASCs, we examined the four factors listed here. For the first factor, it appears the beneficiaries have good access to ambulatory surgical services. The number of ASCs has significantly expanded over the last several years. In addition, the number of beneficiaries receiving ASC services grew by 14.5 percent per year on average between 1998 and 2002.

Although ASCs are still not available in all parts of the country, beneficiaries who are unable to access ASCs may obtain surgical services in other settings such as hospital outpatient departments and, in some cases, physician offices.

At the October meeting we looked at data on growth

in the supply of ASCs. To quickly review, there has been rapid growth in the number of Medicare certified ASCs between 1997 and 2002, which has continued for the first half of 2003.

We've also recently examined changes in the average number of operating rooms per ASC, which is one indicator of surgical capacity. This number stayed constant at 2.5 between 1997 and 2002.

Industry sources tell us that the majority of ASCs are Medicare certified, however we don't know the specific proportion. An industry survey of ASCs finds that Medicare accounts for about 25 to 30 percent of revenues for a typical ASC.

As you requested last time, we are trying to identify ASCs by the types of services in which they specialize, particularly new ones entering the market. However, we've been encountering some problems with the data and don't have this information for today's meeting.

The next factor we looked at is changes in the volume of ASC services. Between 1998 and 2002 the volume of services provided by ASCs to beneficiaries increased by over 60 percent as the chart shows here. The average annual

growth rate during this period was 15 percent. During these years, ASC payment rates increased by less than 1 percent per year, which suggests that the level of payments in 1998 was adequate to sustain high-volume growth. Almost all of the increase in ASC volume was due to more beneficiaries receiving services rather than an increase in the number of services per patient.

Between 2001 and 2002 the following types of procedures grew fastest: colonoscopy, upper GI endoscopy, and minor musculoskeletal procedures which includes interventional pain management services.

There are various factors that could be influencing the growth of ASC services received by beneficiaries but it's difficult to isolate the impact of each factor. First, Medicare payment rates might be more than adequate, particularly given that the current rates are based on 1986 cost data and may reflect productivity gains since then that have reduced costs.

Second, there has been a general shift of surgical services from inpatient hospital to ambulatory settings over the last several years. This shift is related to changes in clinical practice and technology which have expanded the use

of ambulatory surgical procedures such as colonoscopy and cataract removal.

We find that this trend is much more pronounced in ASCs than outpatient departments. Between 1998 and 2002, the volume of ambulatory surgical services provided to Medicare beneficiaries in ASCs grew much faster than the volume of these services in outpatient departments. The average annual growth rate was 15 percent in ASCs as compared to almost 2 percent in outpatient departments.

These differences in growth rates may be related to the profitability of Medicare payments or to other factors. For example, ASCs may offer patients more convenient locations than outpatient departments. Medicare coinsurance is often lower in ASCs. ASCs may offer physicians more control over staffing, the surgical environment and scheduling. In addition, physicians can increase their practice revenues by investing in ASCs.

Our analysis suggests that ASC's have good access to capital. First, there has been rapid growth in the number of ASCs over the last five years, which suggests that new ASCs are able to obtain capital to begin operations.

Most ASCs are independently owned by local

investors while some ASCs partner with larger for-profit corporations. Two of the largest ASC chains experienced substantial revenue and earnings growth in 2002 and are expected to continue growing in 2003.

In summary, the factors we've examined show that there's rapid market entry by new ASCs, high volume growth in the volume of ASC services provided to Medicare beneficiaries, and sufficient access to capital for providers. This suggests that Medicare payments to ASC are more than adequate to cover current costs.

The next part of the update framework is to ask how Medicare payments to ASCs should change for 2005. Several factors could affect the change in the unit cost of ASC services. The first factor is inflation and input prices. The ASC payment system uses the consumer price index for urban consumers to approximate changes in input prices. The CPIU is currently projected to increased by 2.1 percent for fiscal year 2005. ASC costs may also increase due to scientific and technological advances that enhance the quality of care but also raise costs. There are certain mechanisms in the ASC payment system that separately account for the cost of some new technologies such as additional

payments for new types of intraocular lenses used for cataract surgeries.

In addition, high growth in the volume of procedures likely to use new technologies suggest that current payments are adequate to cover their costs. Thus, we do not make an allowance for cost increases due to scientific and technological advances.

The final factor that affects ASC costs is productivity growth. As with other sectors, MedPAC's policy standard for expected productivity growth is 0.9 percent. By subtracting productivity growth from input price inflation, it appears that the cost of ASC services will increase by 1.2 percent in the coming year. We believe that current base payments are at least adequate to cover this increase in costs.

Thus, our draft update recommendation is that there should be no update to payment rates for ASC services for fiscal year 2005. It is based on our conclusion that current Medicare payments to ASCs are more than adequate to cover current costs and are at least adequate to cover the expected 1.2 percent increase in next year's costs. Because this would reflect current law, there would be no spending

implications. We do not believe that this would affect ASC's ability to provide services to beneficiaries.

The Medicare conference agreement requires the Secretary to implement a revised ASC payment system, taking into account a GAO study of whether it would be appropriate to use outpatient procedure categories and relative weights for the ASC payment system. The GAO study is supposed to consider data submitted by ASCs.

Here we take a closer look at the issues involved in revising the ASC payment system based on the outpatient payment system. ASC procedures are currently placed in one of nine broad payment groups, which makes it difficult to pay accurately for individual services. By contrast, the outpatient payment has over 500 payment groups. The use of a greater number of groups could enhance the accuracy of ASC payments.

In addition there is currently significant variation among rates by setting for some high volume surgical services which could create financial incentives to shift service between settings. Using the same grouping of services and relative weights in each setting would likely make the rates more comparable, thus minimizing these

incentives.

Finally, linking the two systems would allow CMS to update ASC procedure groups and weights each year, along with its annual revisions to the outpatient payment system.

This approach does present some concerns, however. The outpatient rates may not reflect the relative costs of individual services which could have a large impact on ASCs that specialize in a narrow range of procedures. If the relative costs of procedures are different in each setting, the outpatient weights may not reflect the relative costs of ASC services.

Finally, outpatient departments are eligible to receive certain payments in addition to the base rate such as pass-through payments for new devices, which ASCs do not receive. Outpatient departments, unlike ASCs, are also allowed to bill separately for radiology or imaging services that are ancillary to surgical procedures. On the other hand, ASCs can bill separately for prosthetic devices such as joint implants used in surgical procedures unlike outpatient departments.

We propose addressing these issues by recommending that the Secretary revise the ASC payment system based on

the outpatient weights and procedure groups but periodically use recent ASC cost data to monitor the adequacy of ASC rates, calibrate the relative weights, and develop a conversion factor that recognizes the lower cost of ASC services compared to outpatient services.

We propose not specifying how the Secretary should collect cost data. The main options appear to be through surveys, cost reports, or perhaps by asking groups of experts to estimate the relative levels of resources used for different services. Each of these approaches would have its pros and cons.

We expect that a conversion factor based on more recent ASC cost data would result in ASC rates that are lower than outpatient rates for the same service, taking into account additional payments received in either setting. This is based on our finding from the March 2003 report that outpatient departments are probably the higher cost setting for two reasons: they have additional regulatory requirements and they treat patients who are more medically complex.

We are currently unable to project the spending implications of this recommendation. Under current law

total payments in a revised ASC payment system must be budget neutral to payments under the old system. Our proposal may not result in budget neutrality because we're recommending that the conversion factor should ensure that ASC rates are lower than outpatient department rates. ASC rates that are higher than outpatient rates would decline, while ASC rates that are significantly lower than outpatient rates would probably increase. And it's unclear how these changes would offset each other.

In terms of provider implications, ASCs that focus on services that currently receive higher rates in ASCs than outpatient departments, such as some endoscopy procedures, would experience payment reductions. However, ASCs that provide services currently reimbursed at much lower levels in ASCs than outpatient departments, such as some orthopedic procedures, might receive higher payments.

We don't expect this recommendation to reduce beneficiaries access to ambulatory surgical services. If some ASCs provide fewer services, beneficiaries could still receive care in outpatient departments.

The next issue relates to the list of procedures paid by Medicare in ASCs. CMS is required by statute to

maintain a list of procedures eligible for payment by Medicare when performed in an ASC. Procedures must meet several criteria to be placed on the list. They must be performed in inpatient settings at least 20 percent of the time, but cannot be performed in physician offices more than 50 percent of the time. A procedure must not exceed 90 minutes of surgery or four hours of recovery time and anesthesia must last no longer than 90 minutes.

There are also clinical safety criteria. For example, a procedure is excluded if it results in extensive blood loss or involves major invasion of body cavities.

CMS is required to update this list every two years. However, the list was not updated between 1995 and March 2003, when it was last expanded. Long gaps between updates make it difficult for the list to keep up with technological changes. They make it possible to perform more services in ASCs.

In addition, the volume in other settings may no longer be a relative criterion for determining what services are clinically appropriate to provided in an ASC. In 1998 CMS proposed eliminating the time limits criteria and reducing the importance of the site of service volume

criteria, but retaining the clinical standards. This proposal has not been implemented.

Instead of maintaining a list of services that are eligible for payment, it might make sense for CMS to create a list of services that are specifically excluded from payments. Unless included in such a list, a service could be paid when performed in an ASC. For example, CMS maintains a list of inpatient only services that are excluded from payments in hospital outpatient departments.

When considering what services to exclude from ASC payment, CMS should probably continue to apply clinical safety standards and exclude services that are likely to require an overnight hospital say. To avoid creating financial incentives for services to shift from physician offices to ASCs, CMS might consider excluding procedures that are routinely performed in physician offices and would be paid significantly more in an ASC.

We propose recommending that after the ASC payment system is revised, the Congress should authorize CMS to replace the current list of approved ASC procedures with a list of procedures that are specifically excluded from payment based on clinical standards and payment differences

between ASCs and physician offices.

We propose that this change occur only after CMS has revised the ASC payment system and reduced payment disparities between ASCs and outpatient departments. Otherwise, opening up the ASC list could drive services from outpatient departments to ASCs because of payment differences.

This recommendation could increase Medicare spending if more surgical services overall are performed over and above the shifted services from other settings to ASCs. On the other hand, if ASCs are paid less than outpatient departments under a revised payment system, Medicare spending could decline if services shift from outpatient settings to ASCs. ASCs would likely to be able to provide a broader range of services, thus improving beneficiaries access to care. Beneficiaries who could obtain services in an ASC instead of an outpatient department would also likely have lower cost sharing.

This concludes my presentation and I look forward to your feedback.

MS. DePARLE: I like recommendation three, I think, if I understand it. So what you're proposing is that

rather than have the agency try to figure out what is clinically appropriate, allow clinicians to figure that out. And with the exception of some things that are specifically excluded, then things can get more quickly diffused into the ambulatory surgical center setting?

MR. WINTER: That's right. That's the idea. The Agency should still continue to look at whether procedures that are being done in outpatient departments are clinically appropriate and safe to perform in an ASC based on the different abilities of each setting.

MS. DePARLE: But it makes it a little easier to get things moving. I think that would save them a lot of time, actually.

On the second recommendation, I don't quite understand -- well, first you said something about you were having trouble with the data on one of the questions we had asked you to look at. What exactly -- data is the issue here. We haven't had any data. So what are you looking at and what are the problems with the data?

MR. WINTER: You and Jack asked me last time to look at what kinds of services ASCs are specializing in, try to identify, try to come up with some kind of matrix for

identifying ASCs by what they provide.

We've been trying to do that linking ASCs to claims data but we've had a lot of problems matching up ASC providers to ASC claims. So that's been the hang up there. We're going to try to work with one of the industry associations and see if they can help us out doing a survey of their own membership, and we're going to continue pushing this Medicare claims data question.

But that's what I was referring to.

MS. DePARLE: That would only be for Medicare. Part of the question here and I think that what Jack was getting at, if I recall. is that if 75 percent or 70 percent of their revenues, of a typical ASCs revenues, are non-Medicare, the business model is different. What I remember him saying is something different is going on, something different is driving this.

You're having a hard time even looking at Medicare claims data. I understand that's hard. But if we're only going to know then about Medicare, that really still doesn't tell us as much as I think I'd like to know about this industry as we're trying to make these recommendations.

MR. WINTER: There is an industry survey that does

classify ASCs by whether they provide a certain service or not. So they find that about half of ASCs provide ophthalmology, 45 percent plastic surgery, 40 percent GI. What they don't say is what percent of their volume these services account for, so it's hard to say what they specialize in. But we are going to try to work with the industry some more and figure out if there's a way we can develop a typology.

MS. DePARLE: On the second recommendation, how does it relate to the GAO study that is being required? Would we be recommending that the Secretary move ahead without that study? Or how do the two relate to each other?

MR. WINTER: That's a good point. The intention here is that subject to the GAO's recommendations, the Secretary should go ahead and do this. But it's an opportunity right now for the Commission to lay down its market in terms of what it thinks a new ASC system should look like, whether it should be designed along the lines of the current outpatient payment system or something different.

Because the GAO report is due January 2005, which would be before the March report after this one. So the

March 2004 report would be the next opportunity.

MS. DePARLE: You're concerned that might be too late.

MR. WINTER: If we wait until March 2005, it might be too late. We could do something in June 2004 as well, if you want to spend more time thinking about it and studying it.

MS. DePARLE: The GAO, are they just looking at the feasibility of doing a payment system that's based on the outpatient payment system?

MR. WINTER: My understanding is that they're supposed to use data submitted by ASCs and other factors, as well, to look at whether it's appropriate to apply the outpatient weights and procedure groups to the ASC system and then make recommendations as to whether that should be implemented or not.

MS. DePARLE: So we would be answering that question. We would be saying, in this recommendation, that it is appropriate.

MR. HACKBARTH: Is GAO looking at the relative cost issue, both the conversion factor and the relative weights, as opposed to analyzing whether it's appropriate to

have a similar system for ASCs versus outpatient departments?

MR. WINTER: The legislation does not specifically say they're supposed to look at the relative costs of an ASC procedure versus an outpatient procedure but only the relatives within each setting. Of course, they may decide to go ahead and do that once they have --

MS. DePARLE: Somebody has to look at that because we're never going to get anywhere. That's part of the problem.

MR. HACKBARTH: My question didn't come out clearly. Let me try again.

Is the mandate to GAO, does it assume that we're talking about a system that links payment for ASCs and hospital outpatient departments? So we're looking at that sort of architecture.

Now the questions that we need to answer are questions about costs and we need data, GAO please go collect that data. So the premise is that the architecture is some sort of a linked system, a synchronization of payment for ASCs and hospital outpatient departments is the premise, I think, isn't it?

MR. WINTER: The question GAO is supposed to answer is whether that process is appropriate. They're supposed to take a look at whether that's appropriate. But you're correct, what we'd be saying here is that we think, in general terms, this framework is appropriate. We do think that the Secretary should periodically collect ASC cost data and make sure that it's appropriate and make some minor adjustments if necessary.

MS. DePARLE: I guess, just to be clear, is GAO in collecting the data from the ASCs going to get some data about cost? Because the problem I have with our recommendation -- and Glenn knows I have this problem -- I don't have a problem with assuming that the architecture should be similar. That's what we proposed in '98 originally. We did not have the data to do the work necessary to set up those two systems, so we didn't move forward. And we haven't moved forward now in six years.

So I object to our presuming lower costs without any data.

MR. HACKBARTH: I don't think that's what this recommendation does, at least as I read it. It assumes the same architecture is the way to go, and I do believe that.

MS. DePARLE: [off microphone.] And I don't disagree with that.

MR. HACKBARTH: But it says that there ought to be data collected to look at the issue of how to set the conversion factor and whether the relative weights ought to be adjusted.

MS. DePARLE: But our recommendation says develop a conversion factor that recognizes the lower cost. And I don't think I have the data to say that.

DR. MILLER: I think your comment is fair and I'll take responsibility for this. I think in our recommendation the point that we wanted to recognize if that our analysis had generally driven us in this direction. And I think the marker we were trying to lay down in talking about the recognition is an expectation that we will find that. And if that's not the case, then the cost data will show that and then we would recognize it on the basis of the cost data.

But our data to this point suggests that it is, in fact, lower. And what we wanted to be clear about is that we're not accepting a budget neutral or higher, because if the payment system right now is driving payments through

that results in them being paid more than OPDs, we didn't want to particularly err on that side of saying well, then that's just the way it needs to be.

So we're trying to set a marker that our expectation is based on our analysis to this point, that is likely to be lower. It may not have done that well in this language, but that's what the intention was.

MS. DePARLE: But isn't our analysis a little speculative? They don't have certain regulatory requirements.

DR. MILLER: Absolutely.

MS. DePARLE: So it's not qualitatively the kind of analysis that we've done on other things. That's the point I've made.

DR. MILLER: That's why, in this recommendation, we are adamant on this point that the data on the cost needs to be collected. So ultimately you can calibrate on the weights and answer definitively the question on the conversion factor.

DR. REISCHAUER: Let me see if I have this right. We're willing to recognize lower costs where they're lower but not higher costs where they're higher, based on the

recommendation we made last year.

MS. DePARLE: Whatever the costs are, they are. Some of them are higher, some of them are lower. If we're going to align it, it should be fair and they should be aligned. So in some cases they should go up. In some cases they should go down.

That's another issue, is this budget neutral or not?

DR. REISCHAUER: That's a question because I thought we were saying it's good to encourage this sector to the extent that it can provide the service at the same cost or lower. But because there are social externalities that we think are negative in the movement of services from OPDs to surgical centers, we're a little leery about paying them whatever their costs in instances where their costs are higher.

Now maybe I'm wrong, but I think that was the tendency.

MS. DePARLE: That's what the Commission said last year.

DR. REISCHAUER: That's what we said last year. But if that's the case, than the sentence here in this

recommendation should say factors that recognize the relative cost of ASC services where lower rather than lower cost, which is what you were objecting to, which sounds like a presumption that always their costs are lower.

DR. MILLER: I think, if we're all talking to each other, we're agreeing at this point because I want to be clear that when you attach it to the OPD system, if that on a relative basis moves services around, it would move services around. The question is sort of the overall conclusion about why would their costs, in general, be higher.

MS. DePARLE: I would have been in favor of parity, not only saying only where lower.

DR. REISCHAUER: I wanted to ask Ariel a couple of things. One is do we know why the requirement for collecting cost data was taken out in this latest legislation?

MR. WINTER: My guess is because Congress might have been a little frustrated that -- either frustrated with the Agency for not redoing the survey since '94 or understanding that the Agency had limited resources and didn't have the ability to redo the survey.

And also reflecting the notion that if you move towards linking the two payment systems, then you may not need cost data because you just update the weights and the procedure groups based on how you do it on the outpatient side. So that you no longer need to worry about -- my guess is this is the thinking -- you no longer need to worry about what the relative costs are for ASC services, because you collect data on relative costs for outpatient services. You just calibrate the relative weights at the same time.

DR. REISCHAUER: The first couple of those reasons you gave strike me as, in a way, outrageous. You haven't done what we've asked you do. Therefore, I'll punish you by not asking you to do it. The limited capability of the Agency, I would have thought, although I'm terribly naive on these kinds of things, that a chunk of money transferred to Price Waterhouse or something could get you an answer here. This is the kind of thing that accounting firms do all the time.

MR. HACKBARTH: They shifted it over to GAO. They said CMS has not done it and so we're going to ask GAO to do it. Presumably, they think GAO will be more responsive.

DR. REISCHAUER: I do, too.

One of the things that interests me about this whole sector is the question of whether the services being provided are primarily substitutes for outpatient services or supplements to. I was wondering if -- this is not for this particular chapter, but over the long run we might want to try and answer that question by looking at the four or five states that have concentrations of these entities and looking at for the Medicare heavy procedures the incidence of those procedures within those states as opposed to the states that don't have many ASCs is significantly higher.

And then to ask the question, does this result in improved outcomes, I mean better health? Or do we think that this is another sign of overutilization? Because in the long run that's the kind of question we should be asking it strikes me.

MR. WINTER: We have an analysis like that underway. We're going to be looking at ASC penetration in various markets and whether that's associated with an overall higher level of use of surgical services. And I like your idea of trying to relate it to outcomes. We'll think some more about how to do that.

MR. MULLER: I want to support the general sense

here that having a payment system that has more than nine categories and more like 500 makes a lot of sense and move in that direction, which I think we were moving towards last year and you're recommending here is good.

I feel like Bob, that we need a conversion factor and obviously getting that after many years of trying to get it, and just reflecting Glenn's conversation, we really need that.

I also think, similar to the conversation we had yesterday on dialysis centers. These ASCs, being more focused, do allow the notions of whether productivity can be achieved in this sector. We had some extended conversation about this yesterday, to really be tested because they see a far more narrow set of patients and conditions and so forth.

So a sense in which what the productivity factor in health care might be, as opposed to the kind of general multifactor productivity factor we use, I think could be tested quite well in a couple of settings like ASCs, dialysis, and so forth, where you don't have all the range of the hundreds of type of DRGs and APCs coming in that you see in the outpatient setting of hospitals. And also you have a different regulatory environment. They're not 24/7,

and so forth.

So I think testing the productivity assumption in this arena would be a good way for us to look, in addition to Bob's question of substitution versus supplement. Which obviously, if it happens in five states -- I mean, in some ways if it's happening in five states more than in 50, you start asking yourself is it medicine or something else that's driving this kind of movement, because if it was happening everywhere to the same extent, understanding at the same time that there are regulatory restrictions in many of the Northeast states that keep this from occurring to the same extent that it happens in the states were, in fact, it did happen.

But if we could really focus on the productivity analysis over the course of the next X years, I think that would be very helpful in this setting.

DR. STOWERS: I wanted to shift gears just a little bit. I appreciated your mentioning the lower coinsurance. Even if a physician is not involved in the ambulatory surgery center and they're getting ready to refer a patient, and especially if the patient has limited resources, it can make a big difference, at least in my

experience, on the financial possibility of the patient that they're facing with an upcoming procedure as to whether I refer them to a physician that's going to do this procedure in an ambulatory surgery center as opposed to the hospital.

So I really appreciated you putting that in here. I'm just wondering if we couldn't quantify that for some of the more common procedures, as to what the difference is and financial responsibility to the patient of whether they go to the hospital or whether they go to an ambulatory surgery center. I think that wouldn't be that difficult to do.

And I know one comes out of one pot of money and one comes out of the other, but I wonder just how complicated it would be to say we're going to apply this set of copay rules -- could we get the copay rules the same for both somehow? And I know that might be a regulatory impossibility, but it may very well be worth looking into. Because no matter how we level this playing field on this end of the deal, if we don't level the playing field on the incentive of where the patients are being sent, We've only accomplished half of our goal there.

So I'd like to see that expanded, so I appreciated you bringing that up.

MR. HACKBARTH: Any others?

MS. DePARLE: Bob raises, and I'm still not clear, so our draft recommendation to, the Congress has in the Medicare bill said that the Secretary should develop a new payment systems that is budget neutral relative to what the projected spending for ASCs were. Our recommendation is not budget neutral? Or is it? I can't tell for sure.

MR. WINTER: It may not be. It depends on -- what they're saying is the conversion factor is based on what would equate payments under the old system to payments under the new system. We're saying the conversion factor should be linked to actual cost data and reflect lower cost of ASCs services where that's shown to be true, based on our discussion today.

So that may end up leading to higher overall ASC payments or lower overall ASC payments. It's hard to tell because about one-third of the payments right now are for services in which the ASC rate is the higher than the outpatient rate, and two-thirds are the reverse. So it's just hard to say how that's going to end up coming out once you implement outpatient weights.

MS. DePARLE: So like the cataract, I remember on

that chart you showed us last year, the cataract procedure where it was paid more in the outpatient setting, for example, right?

MR. WINTER: That's right.

MS. DePARLE: So two-thirds of the procedures are paid more, then this recommendation could lead to higher spending?

MR. WINTER: It could if you end up -- it depends on how much you raise those rates versus how much you lower the ones that are currently higher than the outpatient setting.

MR. SMITH: Which raises the question of whether or not we want to or have an obligation to reiterate our earlier recommendation, which is that ASC rates ought to be lower when they're lower and not exist when they're higher. Bob said it more elegantly than I did.

But partly because we've got some budgetary consent here and partly because we have some institutional concerns, that migrating services to higher cost settings is not in our interest, not in the program's interest. We said that before.

It would seem to me that if we're going to go down

the road of the wording in recommendation two, once we clear up what we mean by lower costs, it seems to me we have an obligation to reiterate the earlier recommendation that ASC costs be recognized when they are lower but not when they're higher, or the ASC rates be recalibrated when they're lower but not when they're higher.

MR. HACKBARTH: I'd personally be happy to see that happen. But even if that is the case, you could still have an increase in spending because some of the cases where the ASC rates are lower, they could move up based on the cost data. But you'd still have that upward limit for any given procedure we're not going to pay more for an ASC.

MR. SMITH: [off microphone.] And we would presume budget neutrality.

MR. HACKBARTH: Right. So when we come back with a recommendation in January, it will include that element in it.

Anybody else on ASCs? Okay, thanks, Ariel.

The last item is SNFs.

DR. SEAGRAVE: Last but not least, I will discuss payment adequacy and updating payments for the skilled nursing facility sector.

As you know, in our March report, we will make an update recommendation for SNF payment rates for fiscal year 2005. In this presentation, I will discuss the steps that we used to come up with our draft recommendations for the coming year in this sector.

As you know, current law calls for an annual update to SNF payment rates equal to the full market basket increase which is currently forecast for fiscal year 2005 at 2.8 percent. This number may, of course, change as the year progresses.

As we've discussed before, freestanding SNFs, those SNFs located in nursing homes, make up about 90 percent of all SNFs. For this reason, we focus much of our attention on the nursing home industry.

This graph identifies the sources of funding for the nursing home industry in 2001. As you can see, the largest funding source was Medicaid followed by beneficiary out-of-pocket spending and Medicare.

On the next four slides, I will briefly summarize market factor evidence we have for the SNF sector this year. Since you've seen most of this before, I will not going into much detail, but I'm happy to answer your questions.

Regarding beneficiary access to care, the evidence we have suggests that the majority of Medicare beneficiaries have no problem accessing SNF services but that certain types of patients with special needs, such as those who have diabetes, need ventilator support, are morbidly obese, or have special feeding requirements may stay in the hospital setting longer before they go to a SNF. We don't know if this is a good or bad outcome for these patients but this finding may point to problems with the distribution of payments in the SNF payment system. I'll return to this point later.

Regarding supply, the overall supply of Medicare certified SNF facilities and SNF beds appears to have reasonably stable since the adoption of the SNF PPS. As you can see from this graph, the number of Medicare freestanding SNFs has grown pretty steadily since 1992. The number of hospital-based SNFs peaked in 1998 and has declined each year since then. From 2002 to 2003, the number of Medicare-certified freestanding SNFs grew by about 2 percent and the number of hospital-based SNFs declined by 9 percent, with hospital-based SNFs returning to approximately the number seen in 1993.

Just a note about this slide, we do not include Medicaid-only SNFs in these numbers because they're not relevant to this discussion. However their members have been declining since 1998.

Analysis of the supply of SNF beds nationwide indicates a similar pattern with the average number of freestanding SNF beds increasing and the average number of hospital-based SNF beds decreasing. Not surprisingly we find evidence that freestanding SNF beds often substitute for hospital-based beds in areas where hospital-based SNFs closed. Overall, in terms of supply, we don't find declines in the availability of SNF beds for Medicare beneficiaries.

Regarding volume of services, volume grew in 2001, the most recent year for which we have data. with discharges increasing by 6 percent, covered days increasing 8 percent, and the average length of stay increasing by about 2 percent.

Regarding quality of care, the evidence is mixed. Studies focusing solely on Medicare beneficiaries tend to find no major changes in quality of care since the SNF PPS. However, a small group of recent studies have found declines in quality among mostly non-Medicare nursing home residents

since the SNF PPS. But it is still unclear how these results translate to quality for Medicare beneficiaries.

Overall we find little evidence to suggest that SNF quality for Medicare beneficiaries has declined in recent years, but it will be important to continue monitoring this area.

Now turning to access to capital. The evidence on access to capital is similarly mixed. On the one hand, CMS's annual analysis of the nursing home industry suggests that access to capital has worsened since 2002, due in part to uncertainties surrounding Medicare and Medicaid payment rates.

On the other hand, nursing homes' Medicaid funding situation for this year at least does not appear to be as bad as analysts initially had predicted. Recent reports by both the Kaiser Commission and GAO suggest that Medicaid nursing home rates remained relatively stable in 2004. Both sources allude to possible changes down the road if states budget crises continue and worsen.

We also find evidence, by the way, that some for-profit SNF stock prices have risen substantially over the past year.

And finally, nursing home market analysts generally continue to view Medicare nursing home payments as favorable for the industry.

I want to pause here and be clear that I'm not suggesting that the evidence says that overall financial performance in the nursing home industry is just fine, but that the evidence does suggest that Medicare payments are at least adequate in this sector. Of course, this leads to the question then that the Commission has been very clear on about whether Medicare should subsidize other payer sources.

In summary, overall the market factor evidence suggests that the majority of Medicare beneficiaries needing SNF services will continue to have access to quality care over the next year. We do remain concerned about the minority of patients who experience delays in accessing care.

Now we turn to some of the new information that you haven't seen before. These are preliminary information on freestanding SNFs' Medicare margins. I'm sorry we were not able to bring you margins for hospital-based SNFs today. We had some difficulty with the data. We will, of course, bring these to you in January.

The middle column represents the aggregate SNF margin for Medicare payments and costs from SNFs' 2001 cost reports. We have used a very conservative methodology in computing this margin. As you can see, we estimate the margin to be about 19 percent in 2001 for all freestanding SNFs. As in the past, we don't see big differences in margins between urban and rural facilities and, if anything, rural facilities tend to look a little better on most of the margin measures.

The far right column contains our projections for SNF Medicare margins for fiscal year 2004. These projections, I want to note, exclude two temporary payment add-ons that were in effect in 2001, but they include the 6.26 percent permanent increase to SNF payment rates that took effect in fiscal year 2004. By January, we will also have 2002 cost report data, which may change our projected numbers somewhat. We don't expect them to change significantly.

Just a couple of quick notes about the distribution of a freestanding margins. In 2001 about 88 percent of Medicare bed days were in freestanding SNFs with positive Medicare margins. As always, there are some

variation among types of facilities. For example, we see slightly lower margins in very small facilities with between one and 20 beds, in government-owned facilities, and in very low Medicare share facilities.

Overall our margin analysis shows that Medicare payments generally exceed SNFs' costs of caring for Medicare beneficiaries.

The last step in forming our draft update recommendations is to consider anticipated cost changes for fiscal year 2005. The best predictor what might be expected to happen to SNF costs in 2005 is what has happened to costs up until now. A number of studies have shown that freestanding SNFs reduced their costs after the SNF PPS, both by negotiating lower prices for contract therapy, substituting lower cost for higher cost labor, decreasing the overall number of therapy staff they employ, and by decreasing the number of minutes of therapy per week they provide.

I want to mention along the lines of cost changes, we are aware of one new quality enhancing, cost increasing technology in this sector, the so-called wound vac. The technology may speed healing time and shorten patients

length of stay. However, SNFs have little incentive to adopt this technology because they are paid on a per diem basis. We don't expect this technology to increase SNFs' cost much over the next year, in part because they have little incentive to adopt it currently. We might consider ways in the future to incent SNFs to adopt this technology.

Next, I present three draft recommendations for your consideration. Our first recommendation, that Congress eliminate the update to SNF payment rates for fiscal year 2005. This would mean a decrease in spending relative to current law. Also, since Medicare payments currently exceed costs, we don't anticipating major implications for beneficiaries or for provider's ability to provide services.

Our second draft recommendation, even though we find that the current pool of money in the system is likely more than adequate, we continue to see problems with the distribution of moneys in the system as evidenced by the delays certain beneficiaries experience in accessing SNF services. Therefore, we propose recommending again, as we did last year, that the Secretary develop a new classification system for care in SNFs. And that until this happens, Congress give the Secretary the authority to remove

some or all of the 6.7 percent add-on currently applied to the rehabilitation RUG groups and reallocate money to the non-rehabilitation RUG groups. We believe this would achieve a better balance of resources among all of the RUG groups.

Because this is a redistribution of money in the system, it would likely be spending neutral. However, it could potentially improve beneficiaries access to services, especially for those beneficiaries who currently experience delays in accessing services. And could lead to a more equal distribution of Medicare payments along providers.

Finally, our third draft recommendation relates to our efforts to monitor and ensure quality of care in SNFs. Although quality of care in SNFs appears to have been stable in recent years, GAO and others consistently find indications of overall low quality of care in nursing homes.

So that MedPAC and others might better study the relationships between nursing costs, total costs, and quality of care, we propose recommending that the Secretary direct SNFs to report nursing costs separately from routine costs on the Medicare cost reports. I want to note that many state Medicaid programs already require nursing homes

to break out these costs.

This recommendation would have no spending impact. It would likely have no immediate impact on beneficiaries, but it could mean a modest cost for providers.

This concludes my presentation. I welcome your questions or comments.

MS. RAPHAEL: The area where I guess I had the most concern, and I'm not as sanguine as you are about quality remaining stable, because in the draft chapter I found it hard to differentiate a Medicare patient from a non-Medicare patient because it's sometimes the same patients, although at one point Medicare is paying and then on the next day Medicaid is paying. And you do say the nursing staffing levels have gone down and deficiencies continue to be high. I think the GAO study indicated 25 percent rate of deficiencies in nursing homes in the last survey. And then on some of the clinical conditions, like UTI, urinary tract infection, the rates have not shown improvement.

So overall, I don't feel that we can say with great comfort that quality has stabilized and is not a cause for concern. I do believe that in nursing homes, to some

extent, nurses are a proxy for quality. Nurses and probably CNAs are an important proxy for quality. So I think that I would like to see some changes in how we cast that.

I don't know if you've also considered the new feeding assistant which is now permitted in nursing homes, and what we think the implications of that might be.

DR. SEAGRAVE: I don't know that we have any data on that yet.

MS. RAPHAEL: But I think that is partly in response to a sense of problems in staffing. Whether that's a good thing or a bad thing, I think is subject to future interpretation. But I think that's another example of concern that staffing levels are not what they need to be in nursing homes and that they continue to have shortages and high turnover rates.

MR. MULLER: Just a brief question. What percentage of the Medicare patients turn into Medicaid patients?

DR. SEAGRAVE: We have relatively old evidence on this. At one point it was thought that about 30 percent do. It may be higher recently.

DR. REISCHAUER: I think the right number that we

want is what fraction of the Medicaid patients are dual eligibles?

MS. BURKE: [off microphone.] Duals are about 12 to 14 percent.

MS. DePARLE: Overall, but in the nursing homes don't you have a sense it's got to be higher than that? So they're not in there as a Medicare SNF patient per se.

DR. SEAGRAVE: We actually are working on developing that number. I don't have it for you yet but we are working on developing that.

MR. MULLER: Nancy-Ann, I misunderstand it then. When they first come in they can come in as Medicare and then when the 100 days is -- and then they become Medicaid.

MS. DePARLE: Eventually.

DR. REISCHAUER: [off microphone.] When we're considering Dave's concerns, we're treating them like Medicaid and somebody else, but we have a responsibility for them in another sense.

MR. MULLER: I understand. That's why the distinction -- just following up on Carol's point -- the distinction between Medicaid and Medicare patients, I think, is just a thinner line than we're saying.

DR. STOWERS: I'm probably a lone voice on this, but having seen some of our facilities that are really struggling along the way, and full well understanding that we're not trying to substitute the Medicaid payments in some of our states that have gone down, it seems like to me, and knowing that their costs have gone up and their liability costs have gone up, and all sorts of things, that are changed this last year, it seems like to me an update that would at least cover inflation and that kind of thing over the last year, the MEI or minus productivity or something, would at least keep this on some kind of a grade along the way, would keep us supplementing it at the same rate we have been along the way.

So it seems like going with no update at all is really backing off, in some way, from what we had been supplementing along the way. So I would think personally that we would give some kind of an update that would at least keep up with their expected increase in expenses. Because what you're showing is that over time their margin is going down. They were at 20 and now they're going down to 14.

DR. MILLER: This may not change your point at

all, and I need to be clear about this. There was two administrative changes last year. They got the market basket increase last year. And then there was an adjustment in the way the market basket was calculated, that gave an additional 3 percent.

DR. SEAGRAVE: Right, it was a market basket forecast error correction for forecast errors that had occurred in 2000 through 2002. So they increased rates by 3 percent beginning October 1st.

And then they also increased them by an additional 3.26 percent for that market basket forecast error correction from 2000 to 2002.

DR. MILLER: And that's all reflected in the numbers that you're presenting here, is that right?

DR. SEAGRAVE: Right. As I said, the 14 percent number -- it's a little misleading to say that they were at 20-something and then went down to 14. The 19 percent margins for 2001, those contained those two temporary payment add-ons. Those are more or less as reported in 2001. So they contain those two temporary payment add-ons that, as you know, expired on October 1st of 2002.

So the 14 percent, we modeled that according to

current law. So that does not contain those two add-ons, but it does contain that 6.26 percent increase that they just got. And that increase is permanently in the rate.

DR. STOWERS: As long as our supplement, which I agree we shouldn't be trying to carry the other big load, that this is just not a good time for us to be providing less overall.

MS. BURKE: Very briefly, because I'm essentially repeating, in part, what Carol and Ray have both commented on.

I am also concerned about the mixed story on the quality issue and indicators that suggest that they are substituting lower cost staff for higher cost staff translates into nursing aides for nurses, which I think in fact has a direct impact ultimately on quality, decreasing the number of therapy staff. I mean, all those, in my view, are not positives. They are, in fact, potentially negatives. The data that we saw in the sort of avoidance, the list of the avoidable admissions, has the smell of some issues occurring in either the nursing home side or the home care side in terms of the treatment of patients.

So understanding, if we can, the source of those

patients may help us understand more fully what is occurring in nursing homes, and if, in fact, whether it's the pneumonias or the UTIs or whatever it happens to be if we, in fact, are seeing an increase out of the nursing home sector, that to me translates into there are real issues here.

So I am also very nervous about presuming that those margins -- I mean, it's Bob's point that there may be enough in the system and the question is whether it's getting to the right places. But I worry about every one of these, decreasing the number of units of therapy, decreasing the number of therapy staff, translating into lower cost staff, or higher cost higher qualified staff, are all things I think that are negatives. And I worry about presuming that all is well and treating it as if we've done the right thing.

DR. SEAGRAVE: Yes, and I think that's why I've indicated that the quality evidence is mixed and we are very concerned about the quality. Part of the problem is that under the PPS, when they're getting a prospective rate, the incentives unfortunately are there to reduce the types of staff that you were alluding to and substitute lower cost

for higher cost staff and those kinds of things. And those incentives are going to be there no matter what the payment rate is. That's part of the problem.

MR. HACKBARTH: I think in both the home health area and the SNF area that's a theme, that there may be some issues of concern about the care. There may be some reason for concern about how the payments are distributed.

Then you get to the question well, is higher update factors a solution for these problems?

DR. REISCHAUER: I was wondering if we could take a subsample of nursing homes that are highly dependent on Medicare and private pay patients and then ones that are heavily dependent on Medicaid, and look at whether there's substantial differences in staffing patterns, in trends in staffing patterns, in application of therapy, et cetera, et cetera.

And then we can determine to what extent this is sort of a fiscal pressure issue as opposed to the way we've chosen to pay these things and the differential incentives. Because it might be a more complex problem.

We discovered in the dialysis area that quality and cost didn't seem to be correlated. And it could be that

margins and quality aren't correlated here. You'd want to look at that.

It's conceivable that we'd come up with some information that then would give some more muscle to Dave's concerns because there's still a lot of Medicare patients in Medicaid dependent nursing homes, and we care about their quality as well as those in the others.

DR. MILLER: I know we're able to, and I think you even did subset low Medicare share and looked at the margins. But to the question of whether you can actually look at the staffing ratios, I guess is that something that we even can do?

DR. SEAGRAVE: CMS does, on the Nursing Home Compare, they do list staffing ratios. And in fact, they break it down somewhat, I think, by RNs and other types.

So to the extent that we can have enough sample size between the two groups that Bob is talking about. I mean, I think we can look at it. It's not going to be super precise, by any stretch of the imagination, but we can maybe do a rough cut.

MR. HACKBARTH: Any other questions or comments?

DR. NELSON: I think Sheila made a really relevant

point and from a physician standpoint oftentimes the question of whether to treatment the pneumonia or the dehydration in the nursing, in the long-term care facility, or transfer the patient to a hospital was based on the question if I leave the patient here and order antibiotics and IVs and so forth, can you do it? Can you handle it?

And there's a certain amount of pride on the part of the staff and often, if they can do it they say yes, we can handle that. But if they say well, we only have one RN during the night shift and we just can't be sure that it will get done, then the decision is to transfer the patient.

So the clinical decisions are often not absolutely clear cut, and there are alternatives that are viable if the ability of the long-term care facility is adequate to provide what the physician needs.

DR. WOLTER: Last year, as I recall, in our recommendations we recommended some type of update for hospital-based SNFs if the reclassification system didn't come to be. And we don't have that margin data to look at this month. I guess we will next month.

I'm wondering if draft recommendation two is intended in some way philosophically to deal with that

issue?

MR. HACKBARTH: Yes, why don't we include that when we come back in January. I don't think that was an intentional omission.

DR. MILLER: But it is also true that the second recommendation to reallocate the money is directed at this point.

MR. HACKBARTH: Any others? Okay, thank you, Suzanne.

We'll now have a brief public comment.

MS. SMITH: Since I seem to be the only one between you and you and making your planes, I will be as succinct as possible.

My name is Alise Smith, I'm with the American Health Care Association and our major concern, of course, is long-term care and a focus on skilled nursing facilities.

I have just a few points and I will run through them as rapidly as possible.

First, regarding the forecast error correction. That is what it was, a forecast error correction. And it was CMS saying fundamentally that that money had already been spent by the SNF sector and that the market basket

three years in a row did not pick it up because we had estimated market baskets and not actual market baskets and thus we got forecast error correction.

Secondly, the issue of the dual eligibles. Well, I don't like doing public math anymore than anyone else, and I hate pulling percentages right off the top of my head. I wish I had a cheat sheet here, but I do believe that a credible figure is 60 percent of the residents of nursing homes are dual eligibles. And I will check on that and provide Susanne with the figure that we have. It is an extremely high figure.

Which leads me to a fundamental point. There are 6 million, now I just saw a Kaiser figure of 7 million dual eligibles in the United States. And their care impacts obviously heavily in costs on the long-term care sector.

There's one interesting point here, regarding Ms. Raphael's comments yesterday on the application problem or the distribution problem in the home health sector. Remember that now there are enormous efforts going out there in the states to shift to home and community-based care. Beneficiaries should be served in the most appropriate site. If it's a nursing home, so be it. If it is home and

community-based care, then that care should be efficient, but it should be well funded, monitored, and the labor market and the people who are trained to care for dual eligibles should be there.

On the skilled nursing side, we have somewhat of an analogous problem with our population being 60 percent dual eligible. Well, we've been here before with our argument about total margins and we understand your argument about not carrying Medicaid on the back of Medicare, but this cannot be ignored.

It's a puzzling fact why the mixture of Medicaid and Medicare has only really historically been broached in the hospital sector with the concept of disproportionate share. Now I don't follow disproportionate share issues and maybe they are somewhat controversial now, but disproportionate share is an add-on, if I'm not wrong, to Medicare. Not to Medicaid, but to account for that high acuity and comorbidities of the Medicare/Medicaid patient. We do not have that, to my knowledge, in home health. We do not have that in the skilled nursing facilities sector.

On the issue of taking 6.7 percent and redistricting it down or elsewhere to clinical categories, I

think there are so many complex issues that have to be addressed to support such a recommendation. In discussions with Corbin Liu at the Urban Institute, I am impressed with the fact that the issue of trying to determine what the real SNF cost drivers are is an exceedingly complex one. By January 2005, Corbin Liu and his colleagues will have given their best shot at a comprehensive analysis of what drives skilled nursing facility costs and how best then to treat those in a prospective payment system.

I will check with someone like Corbin, but I doubt that there's any analysis out there, any data out there, any way possible that CMS, even if they were given authority by Congress, could pick and choose what funds should come out of which categories and to which categories those funds should migrate.

In relation to that, I had thought, given prior sessions, that there was going to be a deeper analysis of hospital costs, including cost allocation across hospitals and hospital systems, and the impacts of that allocation on -- well, call them subsidies or entities that are hospital-based -- that's the correct term, -- such as SNFs. I think we should have some further analysis on why those costs are

high, if they are indeed higher, and some balance to the argument we hear often that it is all due to acuity, some kind of analysis to balance the acuity argument, which we think needs to happen.

Last but not least, and I think I'm picking up on the comment of another commissioner, the issue of stability in these sectors is an extremely important one. Capital access, for example, has been horrendous in the SNF sector. We think it may be improving now, but that is difficult to determine.

These sectors, these health care sectors, are very large ships that do not turn very easily on a dime. When you look at issues like beneficiary access or capital access, I am wondering if there could be some deeper explanation of how good is good, how bad is bad, and how can you start to tell when good can turn to bad?

What I'm trying to say is that capital access, which he hoped would now be improving, if we lose an update factor, could start back down in the wrong direction. There has to be some horizon, some sense of what might be up there on the horizon, that the decisions that you're making today will impact.

I just think it would be helpful if a somewhat deeper explanation could be provided in the final report on these issues of if you do, how you try to determine the cumulative effect of a decision made today and how fast it will affect a sector and what the results might be.

At any rate, thank you very much for listening.

MR. FENIGER: Randy Feniger with the Federated Ambulatory Surgery Association. I, too, will try to respect your flight times, although I've been in Washington long enough to know that nothing I will ever say will keep either a commissioner or a congressman from missing a plane. So if you need to leave, you will of course probably get up and leave.

I want to really address three items quickly. The ASC industry and its relationship to Medicare is poised to change. The Congressional action in the Medicare bill that was just enacted will clearly do that, assuming the Department does its own job, and I assume they will, by 2008 we will have a very different system.

I was pleased to see that the Commission and its staff have begun to incorporate some of that thinking in their own recommendations that they are presenting to you,

because I think that really is where your emphasis ought to be, where are we going, not where have we been. And I think that's where the Commission can make the most valuable contribution over the next months and years is in looking at that change, answering some of the questions that were raised today about relationships between HOPD, ASC costs, services, et cetera.

I hope we can get away from the notion or the discussion of the fact that there are a few procedures that paid in the ASC more than they are paid in the hospital outpatient department. We, I think, spend too much time talking about 327 procedures out of the total 2,300 or so that are covered under Medicare. Perhaps what we ought to concentrate on is all of the other procedures that are poorly paid in the ASC compared to the hospital, and the impact that has on patient copays and their out-of-pocket costs because the services are generally not available in the ASC. It might be interesting to look at that.

Our industry is frozen until 2009. Hospital outpatient got 4.5 percent this year. There are not frozen. I think any differences in payment, even without changing the payment systems, will vanish while we stay at zero and

they keep growing at 4.5 percent or some comparable clip.

The migration of services out of the hospital is inevitable. It's happening more rapidly now, it is happening to ASCs, it is moving to physician offices, it is moving to hospitals that specialize in certain kinds of care. I think what the Commission should do in looking at the ASC, and really looking at many other kinds of providers, but particularly ASCs, is think about what is the appropriate place to provide the care? Where can we provide it safely, most effectively, and most cost efficiently, whatever that setting is.

I heard some comments that seemed to me to be sort of the hospital as we have known it since the 14th century is entitled to be preserved, ergo we can't possibly change the payment system for ASCs or some other because we'll do some societal harm. Rather than think that way, I think the Commission could profit by looking at what are those services that the community hospital provides best, compared to other settings, and how can we reimburse them, whether it is through private plans or Medicare, your particular bailiwick, in ways that maintain their viability, rather than saying we're not going to innovate, we're not going to

allow the transfer or migration of services from one setting to another because we have to protect something.

I don't think there is a provider entitlement to Medicare. I think that goes to the patient. I think Medicare ought to look to the best possible use of its dollars.

ASCs work for patients and they work for physicians and the staff. The growth that you have seen described to you, I think is a very positive thing. I don't think it's going to stop. It has obviously curtailed to some extent by state regulatory environments, insurance environments in different parts of the country. But this is a model that works very well and I think it is one that the government, and through your advice the Congress, should encourage through appropriate and proper reimbursement, rather than discourage.

We look forward to working with the staff and with the Commissioners as we move forward to a new payment system, and we hope that most of your energy will be devoted to that particular effort because we think that your experience can bring great value to that discussion and debate.

Thank you.

MR. HACKBARTH: Okay, we're finished. Thank you very much and we'll see you in January.

[Whereupon, at 11:27 a.m., the meeting was adjourned.]