MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
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Wednesday, January 14, 2004
10:19 a.m.*

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
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CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

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P R O C E E D I N G S

MR. HACKBARTH: Welcome to our guests. If you could take your seats, please.

Today and tomorrow we will be completing at least the public segment of our work on the March 2004 report, and that includes our votes on update recommendations for the various sectors.

This morning we begin with dialysis. Nancy?

MS. RAY: Good morning.

Recall last month we discussed two aspects of outpatient dialysis payment policies. First, we discussed assessing payment adequacy and updating the composite rate for 2005. We do this annually so that Medicare's payments can cover efficient providers' costs and in doing so maintain beneficiaries' access to care.

The second issue we discussed last month concerned linking payments to quality, and in doing so improving the quality of outpatient dialysis care.

Currently Medicare has no mechanism to directly reward providers and here we're talking about dialysis facilities and the physicians who treat dialysis patients who improve quality. Recall that in

our June 2003 report the Commission endorsed using quality incentives.

So let's move on to our assessment of payment adequacy. Our framework examines six factors to assess payment adequacy and the first is beneficiaries' access. Here we've concluded that beneficiaries don't appear to be facing systematic barriers in accessing care. We did an analysis of the pattern of facility closures, and this suggests that beneficiaries should not be having problems accessing care in rural areas, HPSAs. In addition, the percentage of the population that is minority and that the percentage of the households receiving public assistance income does not appear to be correlated with facility closures. Rather, facility closures seem to be associated with facilities that are small, hospital-based, and non-profit.

A second factor we consider in our payment adequacy framework is the volume of services. And here we've looked at the volume of services in terms of Medicare payments because we don't have a common unit. And let me just spend a little bit of time talking about each of these bars.

The first bar shows the average annual growth in payments for composite rate services between 1996 and 2001. These have been growing by about 6 percent. The growth is primarily being driven by the growth in the beneficiary population, which is also roughly at about 6 percent.

The next bar shows a 12 percent average annual growth in payments for erythropoietin. This bar, the increase is being driven both by the increase in the patient population as well as by the increasing dose of erythropoietin between 1996 and 2001. Recall that erythropoietin, the payment rate is set by Congress and that payment rate was not changed between 1996 and 2001.

The third bar is the rate of growth for other injectable drugs. This includes vitamin D analogs, injectable iron, injectable antibiotics. Between 1996 and 2001 the average annual growth in payments for these drugs was about 25 percent. The growth in these services is being driven by a combination of the growth in the patient population, the increasing acquisition cost because there has been some substitution from older drugs to more new costly drugs.

Your mailing materials also note that there is some variation in the use of these drugs by provider type.

So here we can conclude that the volume of services is growing, is keeping up with the number of patients.

A third factor we look at in our framework is quality of care. Here we've concluded that quality is improving for some measures. CMS's data shows substantial improvements in dialysis adequacy and anemia between 1993 and 2001. However, CMS's data also show that other measures are flat, specifically nutritional measures and vascular access care. I think this demonstrates the need for continued efforts to improve quality and to address these continued concerns about dialysis quality. Later on in the presentation we will discuss the use of quality incentives as a means to improve quality.

This slide shows the proportion of for-profit facilities is growing. We show this as an indirect measure this time of access to capital, which appears to be sufficient. Last month you had asked about the

growth in the for-profit chains and where this growth was coming from. So we compiled information from their SEC filings and annual reports and that showed that in 2002 the four major national chains, they opened 104 facilities and acquired 35 facilities in 2002. So between the openings in 2001 and -- I'm sorry, total number in 2001 and total number in 2002, there was about roughly a 5 percent growth in the number of facilities operated by the four major chains.

Just to give you a frame of reference, in 2002 there was a total of about 4000 dialysis facilities and about two-thirds were operated by these four national chains.

Let's move on now to the Medicare margin. Here we have calculated it for 2001. We used 2001 cost report data because of the low proportion of facilities that are in the file available from CMS for 2002.

So here we see that the Medicare margin is 5.2 percent for all facilities, 5.4 percent for urban facilities and 4.3 percent for rural. These 2001 date are adjusted by an audit factor. 1996 is the most recent year that cost reports were audited. Our

analysis indicates that audited costs are 96 percent of reported costs. Recall that ProPAC included an audit factor in their update analyses and an older audit found that audited costs were 88 percent of reported costs.

I do want to mention here that data presented by the major chains, they have used their 2002 data and they have calculated a 2002 margin of basically zero, roughly zero. We have a couple of concerns with this. First, it does not include the audit factor. And second, we have issues with how they have cleaned the data.

So now let's move on to our estimated Medicare margin for 2004. We start our estimation process by beginning with our 2001 payments and current law does not update the composite rate for 2002, 2003 or 2004. So projecting out our 2001 data to 2004, it yields a margin of 2.7 percent. This includes a conservative assumption about the increasing proportion of payments for injectable drugs relative to composite rate services. If you remove that conservative assumption, the margin would be lowered by .6 of a percent. So it would be lowered to 2.1 percent.

So to summarize, our analysis of market factors suggest that beneficiaries are not -- go ahead

MR. HACKBARTH: I was thinking about what you just said and I just want to make sure I understand the nature of the conservative assumption.

MS. RAY: Here's what we did. If you recall in your mailing materials, we showed that the proportion of payments for injectable drugs relative to composite rate services has increased from 1996 it was 30 percent. In 2001 it was 40 percent. But I only used the most recent three-year trend from 1999 to 2001. And there it's actually -- it's a 37 percent to 41 percent increase. So the 2.7 percent number would have been higher if I used the '96 to '01 trend for the longer time period because the share has increased more for that time frame than the most recent couple of years.

DR. ROWE: [off microphone.] So what do you think the Medicare margin actually is?

MS. RAY: The Medicare margin is 2.7 percent if we -- when we project out from 2001 to 2004, if we increase the share of injectable payments relative to composite rate payments from 41 percent to about 43

percent.

MR. HACKBARTH: And if we assume that there's no growth.

MS. RAY: Then it would be 2.1 percent. I'm sorry if I wasn't clear the first time.

DR. ROWE: So it's 2.1 to 2.7 percent.

MR. HACKBARTH: 2.1 if the relationship between injectables and dialysis stayed the same as it was in 2001.

MS. RAY: Yes.

MR. HACKBARTH: 2.7 if injectables d continued to grow relative to the composite payment.

MS. RAY: Yes.

So to summarize our market factors, again no systematic problems in accessing care for beneficiaries. I showed you at the last meeting that providers seem to have sufficient capacity to treat patients. The number of in-center hemodialysis stations is keeping up with patients. There is a growing volume of services, as indicated by the payment data. We see improving quality on some measures. And there appears to be sufficient access to capital.

So moving to the second part of our update framework, how should Medicare change payments in calendar year 2005? There are two important factors to consider here. The first, our framework reflects our policy goal that in the aggregate providers should be able to improve their efficiency while maintaining service quality.

The second is the change in input prices between 2004 and 2005. Past years we've solely relied on the Commission's market basket to estimate the costs in the next payment year. And so the Commission's market basket estimates costs will rise by 2.3 percent between 2004 and 2005. CMS just released their dialysis market basket, they released it this year. This market basket estimates costs will rise by 3 percent between 2004 and 2005.

Our likely direction is to move to the CMS market basket in the future. However, we have a few technical issues that we raised in our October report on modernizing the dialysis payment system and we would like to work with the Agency on these issues. The two important issues are the weighting of the cost

categories and the change in the distribution of services when audited data are used.

So using these two market baskets and including our policy goal for productivity, we estimate that efficient providers' costs will rise by 1.4 to 2.1 percent between 2004 and 2005. That tenth of a percent difference is because of the new dialysis market basket that CMS just released.

Let's just briefly discuss the two important payment changes by DIMA in 2005. DIMA increases the composite rate by 1.6 percent. DIMA also makes another important change to the outpatient dialysis payment system. It case-mix adjusts the payment for composite rate services and the difference between payments for and the cost of injectable drugs. That is the spread on the injectable drugs. It also pays the acquisition costs for injectable drugs.

Just to let you know, to keep this in mind, that CBO scored this latter provision, the case-mix adjustment and the paying based on the acquisition costs, as budget neutral.

So this led us to our draft recommendation

that Congress should maintain current law and update the composite rate by 1.6 percent for calendar year 2005. This would have no spending implications relative to current law.

DR. ROWE: Thank you, Nancy.

I need some help and here's my concern. Somewhere along this logic train I'm making a serious mistake but Medicare is the major source of revenue for many of these facilities. And thus, the Medicare margin is probably a reasonable proxy for the overall margin unless commercial payers such as myself are paying something that's much, much higher and represents a much larger portion of the population, and I think we do. But you can tell us what the overall margins are.

You're talking about overall margins depending on this one issue we're talking about. Pre-tax, I'm assuming, this is pre-tax of 2.1 to 2.7 percent, and CMS says the costs are going to increase 3 percent. We differ a little bit with their analysis and we think the costs may increase somewhere between 1.4 and 2.1 percent and we're going to increase by 1.6 percent. We're going to drive these people out of -- I don't understand how

they can have access to capital at that rate. I don't understand how their stock prices are doing so well. I don't understand why more people are entering the market. There's something wrong here. What am I missing? Where are they making the money?

DR. NEWHOUSE: [off microphone.] Epo.

DR. ROWE: But epo is paid by Medicare.

MR. HACKBARTH: The margin is calculated including the drugs.

DR. ROWE: No. The Medicare margin was 2.1 to 2.7 inclusive, everything that Medicare pays for. So that's not the answer. What is the answer?

DR. MILLER: Let me ask one thing to clarify. The margins that we reported, the 2.7, includes the drugs and the composite rate?

MS. RAY: Yes.

DR. MILLER: So that's the first clarification. And then the second point is this update, the 1.6, applies to the composite rate?

MS. RAY: Yes.

DR. ROWE: So is there any increase in the drugs?

MS. RAY: Drugs will continue to be paid as they occur --

DR. ROWE: But this DIMA thing is budget neutral.

MS. RAY: That's right. For 2005, that's right.

DR. ROWE: So why wouldn't a prudent investor buy a share of these -- I mean, I must be missing some huge thing here.

MR. SMITH: [off microphone.] Budget neutral, Jack, doesn't mean less money. It means less money relative to current law. It will be more money --

DR. ROWE: I understand, but is there enough there to make this a -- are these pre-tax margins, first of all?

MS. RAY: The margins represent Medicare payments to allowable costs.

DR. ROWE: So if we take a number like 2.5, so that's 1.5 after tax. That's inconsistent with the access to capital, the stock performance, the increase in the -- isn't it?

MR. HACKBARTH: I think, in part, Jack, this

is why we look at factors other than just the margin. All of the other indicators, including the rapid growth of the for-profit piece of the industry, suggest to me that the payments are adequate.

DR. ROWE: I understand. I agree. Are the returns on capital -- do you know what the returns on capital are?

DR. REISCHAUER: You don't look at the margin on revenues to determine the profitability of a company. I mean, supermarkets operate at less than 1 percent. It's the invested capital.

DR. ROWE: I understand. I just asked what the return on capital was.

MS. RAY: I'd have to get back to you on that.

DR. ROWE: I'm not trying to make a case for or against. I'm just trying to connect all these dots and I'm asking what I'm missing. And maybe the returns on capital are 35 percent, for all I know. But I would think this is a pretty capital intensive business and, in fact, they're not that high. But I don't know.

It's a puzzlement, but thank you for telling me how you measure the profitability of a company. I

appreciate it.

DR. REISCHAUER: You asked what you were missing and you beat up Nancy left and right. And then, at the end, you try and slip in something so we don't --

DR. ROWE: That's why I thanked you but I slipped it in before you mentioned it.

MR. HACKBARTH: Usually, it takes us a while to get to this point, and here we are the first presentation. Sheila?

MS. BURKE: Nancy, good job. I have a couple of questions on the chapter and how we describe what's going on as compared to Jack's issue around the recommendations.

Twofold. One, there is a discussion in the chapter about two-thirds of free-standing facilities that were opened and your comment about the continued opening of free-standing, and the comment made that the openings suggest that there is adequate profitability and access to capital.

What is not discussed in the chapter at all is, in fact, the implications of the absolute decline in non-profits, the continued decline and the continued

increase in for-profits and what, in fact, is occurring with respect to the non-profits. There is an observation that's specific to the adequacy related to for-profits. There is nothing about why, in fact, we continue to see a decline in non-profits in our discussion. And so that's just an area that we may want to give some attention to.

The second issue is really my trying to understand, although this is a relatively small percentage of the population, and that is what is occurring with those patients who have chosen to do in-home as compared to in-center dialysis?

In the conversation you talk a bit about the inequity of the treatment of drug costs for the home-based patient who only has epo taken care of, but none of the other drug costs. And of course, the new legislation will potentially exacerbated -- well, it certainly won't do anything to address has issue with respect to the in-home patient.

I wondered whether there was attention that needed to be given to that patient, what was happened with respect to the equity issues with the in-home

patient, whether the policies in fact continue to encourage people to go in-center, and if there is a reason to do that for purposes of quality. Because the other issue that is not specifically pointed out is you note that there has been some progress in the context of some measures but less so in others. What I don't know is whether there is a difference between the measures quality and the impact on the in-center patient and the at-home patient, whether we see dramatic differences, whether it is in nutrition issues, presence of anemia, issues in terms of the site treatment.

It would be helpful to understand do we want a policy that, in fact, encourages people to go in-center as compared to stay at home? And has there been a radical difference, or is there a real difference in the quality indicators between those two sets of patients? And if there is, then it would seem to me that should relate to some kind of a policy over the long term in terms of reimbursement and what it is we want to encourage or discourage.

Again, it's a relative small percentage of the population but it is still a continuing population that

has chosen peritoneal and chosen to stay home.

MS. RAY: Right. Just two points to add on, and we will definitely augment the chapter with the quality information and address those points. Just two points right now, however.

Remember that the composite rate as its constructed right now actually gives an incentive for peritoneal dialysis. And despite that incentive, and I included this in your mailing materials, the proportion of peritoneal patients has declined roughly by about 10 percent in the last decade.

MR. FEEZOR: [off microphone.] Incentive to whom?

MS. RAY: If you just looked at the composite rate payment to the provider because peritoneal costs are, on average, lower than the in-center because you don't have the capital costs.

DR. REISCHAUER: Nancy, on page 16 you referred to the fact that some of these chains have their own laboratories and it wasn't clear whether you were saying they make excess profits in the laboratory business and those aren't reflected in these margins,

that they overuse laboratory service because of this. I think if we're going to put something like this in, we have to say why we're doing it and whether it's really relevant whether that's within the same corporate entity versus there's some independent laboratory somewhere that's making a bundle on this. It sort of made me a little uncomfortable the way we had it in the text.

MS. RAY: I was not in any way meaning to suggest that there's any overuse of laboratory services. Rather, there are certain laboratory tests that are paid for outside of the composite rate if they go above a certain amount per month and so forth. So those are sent out to the laboratory and Medicare pays the laboratory. It just so happens that the national chains own their own laboratories.

So the payments and costs associated with those services that are associated with the dialysis treatment are not included in our payment margin.

DR. REISCHAUER: I understand that, but we don't want to have a payment that's adequate only if you run a laboratory on the side. What you're basically saying is so these guys might not go out of visit

because they're selling cars or doing something else on the side. But that's really not relevant to what the payment level should be for dialysis treatment.

MS. RAY: I was not suggesting that, but in keeping with our recommendation of broadening the bundle and including all services to the extent possible associated with the dialysis treatment, just like our margins have included the use of injectable drugs in a perfect world, we have included separately billable drugs, we would want to include these separately billable lab tests because they are associated with the dialysis treatment. And we can't because it would be -- well, we not yet because it's a very tough claims level analysis to do that.

But the fact remains that I think ultimately we would want to include these in the broader bundle. And that's why I mentioned them when we're thinking about payment adequacy.

DR. REISCHAUER: [off microphone.] I agree with that but there's sort of an innuendo here.

MS. RAY: I hear you. We'll address that.

MR. FEEZOR: Nancy, three questions. Sheila

touched on one about the quality of home versus institutional. But in your access, was there any significant difference between CON and non-CON states, that you could determine? Or was that discernable?

MS. RAY: I did not do it that way. For the next cycle we could take a look at that.

MR. FEEZOR: Moving to the patient satisfaction survey that's coming online, will we be able to break down -- will that, do you think, reflect such issues as drive time, so that we'll have yet a finer, more granular cut in terms of access?

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

MR. FEEZOR: We have a patient satisfaction survey that's coming online, right? I was just trying to find out if that would hit such things as differences between say small facilities versus large facilities, drive times, and things like that. Do you know?

MS. RAY: I'm going to have to check with AHRQ and CMS to see exactly what measures they're including.

MR. FEEZOR: Do you know whether any of the licensure requirements which of course is largely state as well, whether they have any required backup capacity

so that if in case of disasters or major dislocations? I'd love to hear that. That's something we've seen some experience in that probably needs to be looked at, not so much from this body but the industry at large.

MS. DePARLE: At our December meeting, we talked some about using the CMS market basket versus the one that we had been using for some time. And it sounds like you're inclined to move towards the CMS one. But in the discussion of the chapter you raised two issues about it, that CMS does not indicate how frequently the base weights will be updated, and that CMS does not specifically address whether it used audited cost report data. Have we asked them? Those seem like pretty simple yes or no questions to figure out.

MS. RAY: We're in the process of talking.

MS. DePARLE: Does that mean that this might change between what we vote on today and when -- it seems like they could answer this pretty quickly. And if they did, then might we not just say okay, we're going to use CMS's market basket?

DR. MILLER: Nancy Ann, CMS is thinking about these issues. We have not gotten an answer yet.

MS. DePARLE: But we have asked them?

DR. MILLER: We have asked them and I would not anticipate getting answers between now and when we have to go to print.

MS. DePARLE: These questions seem like simple ones and it always used to annoy me when people wouldn't just ask. Did you use audited cost report data or did you not?

DR. MILLER: I can assure you we're not just sitting in our offices. We have definitely asked this question and I think CMS is thinking about what went on and what they would do to address these issues.

MS. DePARLE: Just one more thing. I haven't gotten to make this point yet this morning. Is this 2001 data we're basing this off of, am I right?

MS. RAY: The cost report? Yes.

MS. DePARLE: So we're making a recommendation for 2005 and, I know you agree with this but...

MS. RAY: The 2002 cost report file had about 40 percent of all the facilities. It was just way underreported compared to previous years.

MS. DePARLE: Let's break that down. That's

because they don't turn them in on time?

MS. RAY: I don't exactly know the reasons for that. It could be the facilities. It could be the FIs. It could be CMS. There are a number of steps here that are involved.

MS. DePARLE: It seems to me that everyone, all of those people, have an interest in having accurate data. I know we do. So I don't know if there's some way to reflect that in our recommendations but there aren't many businesses where I think you'd be making recommendations about what to pay for a year from now based on data from four years ago. Thanks.

MS. BURKE: If I could just add, Nancy and Nancy Ann, the same thing struck me when I read in the text that only 41 percent of the '02 cost reports were available. And I think, in fact -- that's simply stated as a fact in the text. I would, in fact, say something further about that, that our preference would be certainly to have been, but unfortunately for a variety of reasons -- something to highlight the fact that we're basing it on '01 because we didn't have '02, or we only had 40 percent of '02 is just outrageous. I think we

ought to make note of that fact. It's not that that would be our preference by any stretch.

DR. ROWE: On page 13, you do include the returns on -- the term you use is return on equity. There's return on capital, return on economic capital, different kinds of ways to look at this. But return on equity, the range is 11 to 65 percent, which is a modestly broad range so it's hard to know how to interpret that.

But you do also indicate that three-quarters of the patients are on Medicare and that they account for about 57 percent of the revenues. So pushing some numbers around here a little bit, it does look as if they're making from the commercial payers, whoever they may be, significantly more if the costs of all patients are the same. But since that's only one-quarter of the patients when you add it all up, I still only get to returns that are less than 5 percent, in the 3 percent range pre-tax. So it still is modest.

Although as I say, it seems inconsistent with the stock prices going up and the access increasing and everything else. So it just doesn't seem to meet what

most investors would see as attractive. So I think it's worth pushing this around, talking with some analysts who are in this space and getting a sense of it so we can connect the dots.

MR. SMITH: But, Jack, as you push the numbers around, I the problem is you're still assuming that the return on capital is the weighted average of the margins from different payers. It's not true. The return on capital is the pre-tax profit of the operation over the equity invested by investors.

DR. ROWE: I'm accepting the return on capital on page 13.

MR. SMITH: I understand but the return on capital and the weighted average of the margins by payers will not be equal. These folks are in the real estate business, among other things.

DR. ROWE: I understand.

MR. SMITH: So trying to figure out why they aren't the same thing, I don't think, is a very useful exercise.

DR. ROWE: I'm not trying to equate them. I see them as related not necessarily orthogonal but two

separate ways to look at the valuation and I'm just trying to understand with the numbers we're given why -- it just looks to me like maybe they're making a lot more on Medicare than we're calculating is the point here. That's my point because if they weren't why are they doing so well.

MR. SMITH: That's a possible inference, for sure.

DR. ROWE: We just need to go through the whole thing again and make sure we got this right.

MR. HACKBARTH: We need to move on to the second recommendation. Nancy, do you want to do that piece of the presentation?

MS. RAY: Recall that the Commission expressed an urgent need to improve quality in our June 2000 report and endorsed the use of linking payments to quality. Medicare does not have a mechanism to directly reward facilities and physicians treating dialysis patients for improving care and making investments in improving care. Although adequacy in anemia status has improved, other measures have not. And, as pointed out in your mailing materials, mortality and rates of

hospitalization remain high with very little change over the past decade.

We looked at the feasibility of implementing quality incentives for outpatient dialysis services. And here we conclude that it does appear to be feasible. Again, I just want to make it very clear by the dialysis sector we mean both dialysis facilities and physicians treating dialysis patients. The actions of both facilities and physicians affect patients' quality of care.

So we looked at four aspects to assess the feasibility of implementing incentives. We do have measures are available that are evidence-based, developed by third parties, and agreed upon by the majority of providers. CMS can collect provider-specific information without excessive burden on providers. Data on adequacy and anemia are collected on claims. And there is an ongoing effort to collect clinical data by linking facilities with the ESRD networks and CMS.

Data are available to case-mix measures so that providers and not discouraged from taking riskier

or more complex patients. As set forth in your mailing brief, providers are required to report clinical information about each patient when they are incident. There are some 17 comorbidities, patient weight, ability to ambulate and transfer. Of course, this information can always be augmented by Part A and Part B payment claims.

Finally, history has shown that providers can improve upon some aspects of quality, at least on adequacy and anemia status.

Your mailing materials include some key implication issues that the Secretary will need to think about when implementing incentives.

We were guided by two principles when thinking about these implementation issues. First, that the incentives, there their improvements on quality should reach as many patients as possible. And two, that their adverse consequences, such as cherry-picking, should be minimized.

So some of the key implementation issues include how should quality be measured. Here we've discussed basing it on a combination of both quality

improvement and meeting national averages or targets. By using both methods, providers at both ends of the quality spectrum will be able to be rewarded. In this way we will be reaching a large share of providers. Consequently, the quality improvement effects of incentives will touch upon as many patients as possible.

Second, how would you pay? In here, we discuss basing this on a small share, say 1 percent of total payments. This would discouraged providers from de-emphasizing other quality improvement efforts and it would minimize the adverse effect on providers who do not meet the quality criteria.

We spent a fair amount of time discussing which quality measures used. Here we think that aspects of dialysis adequacy, anemia, nutrition, vascular access and bone disease can all be linked to payment.

Finally, your mailing materials include other implementations the Secretary will need to consider, including collaborating with patients and provider groups, keeping the measures current over time, developing uniform ways to measure the indicators, and to verify the data collected.

Finally, it's worth noting that this will increase the administrative responsibilities for both CMS and its contractors.

So this led us to our second recommendation, that Congress should establish a quality incentive payment policy for outpatient dialysis services. This has no spending implications relative to current law.

MS. ROSENBLATT: I'm going to make this point when we talk about M+C as well, and I think I made this point at our last meeting. I think doing quality incentives is great. My concern is in the context of the Medicare system and the way it's funded, what does it mean to set aside a pool of money for this?

Because if we were doing it in the private sector, as many do, in an HMO, a lot of capitated payments end up with a withhold. And that withhold money is actually set aside, a liability is established on the balance sheet. You can point to it. There's sort of real money being put aside.

My concern in this context is just what does this mean in the program? Or would all the providers see this as just a way of cutting back 1 percent and the

pool of money does not exist. That's my concern.

MR. HACKBARTH: Let me make sure I understand. So your concern is that the money "will be withheld" but not necessarily paid out and unless you can see it --

MS. ROSENBLATT: It will be withheld but it's not set aside anywhere so it will be spent elsewhere. There's no liability set up for it.

DR. MILLER: Again, what we're articulating here are a set of principles, so there's probably different mechanisms that could be thought through, but the cleanest way to do this would be if you decided it was 1 percent, you would pay 99 cents on a claim, have the indication of how much you've paid out. And at the end of the year, based on whatever your measures, cut a second set of checks. I think that's a way it could be accomplished.

MR. HACKBARTH: Are you concerned, Alice, that the thresholds for improvement will be set so high that nobody will attain them and so there won't be any payout of quality incentives?

MS. ROSENBLATT: That's part of it. What then, if no providers qualify for it and you've ended up

decreasing payments by 1 percent?

DR. MILLER: One of the things that we're trying to be clear about in setting up -- well, the slide on the principles. There's a couple of things here.

We said and articulated all through the last meeting and this meeting, we're going to try to be very clear on this, and this will be true on M+C, too. So just to get out ahead of it.

It should be both attainment and improvement. So that a person at a lower end of the distribution, if they move a certain -- and there's lots of ways to do this, percentages, points, whatever is -- they get something.

The second way that you assure that the money travels out is you try and determine, either looking at the measures or the percentages -- and the way Nancy was speaking to this is that the most patients are reached by this.

Certainly initially you would want this to travel back to -- I don't know what the exact percentage is, but a relatively large percentage of agencies. And

you can do that by setting the standards in a way that you're moving up the tail of the distribution.

Another point is that Nancy has said very clearly that what we want to do with this is bring in new measures over time. So where everybody is, one concern you might have is everybody's already at this particular measure. But she's been talking about -- and this is where I'm going to lose it here really quickly -- but nutrition and vascular access. Those are new measures and this is the way you keep quality improvement moving is moving up on existing measures and bringing new measures in. And arguably facilities should be able to play on all of that, those dimensions. I think that's the thought.

MR. HACKBARTH: There are many specific decisions that need to be made to operationalize this concept of an incentive payment. And we're not CMS. We're not an operating agency. We're not really in a position to dot all of the I's and cross all the T's. I think we would be going beyond our expertise if we try to define it down to every last detail.

Conceptually, it is not our intent to withhold

money and then not pay it out. Our goal, the objective here is to provide a reward for improving quality. I think it's entirely appropriate for us in the text to emphasize that we want the money paid out to reward improvement. It's not about trying to find another way to take money out of the system.

But I don't want to go so far as to define formulas on exactly how it's going to be paid out. I think that would be inappropriate for us to do.

MS. ROSENBLATT: Can I just push it a little bit more and ask the question is it feasible for these payments to be made? These types of payments are made by Medicare intermediates. I don't see Medicare intermediaries being able to do this. I think CMS itself would need to do this, I don't know, maybe issue memos to -- it just seems to me the implementation of this is pretty difficult.

I know we can't think through all the details, but I'm just trying to get us to think through at sort of the first cut, are we recommending something that can really happen?

MS. RAY: I would just like to put on the

table that CMS is already proposing to link payment to quality in the new ESRD disease management demo. So I think the agency has already thought through some of these issues. Again, in the new demo, they will again be paying both on the basis of improvement and attainment.

DR. NEWHOUSE: I thought the analogy to what Alice was raising first was was this object neutral ex ante or ex post? So the analogy would be to the hospital outlier system where the threshold is set ex ante, 5 percent is knocked off the base rate, and then however much money is paid out is paid out. And it may or may not be 5 percent at the end of the day versus some system that, in fact, guaranteed that 100 percent would be paid out at the end of the day.

I don't have a strong view about whether we should comment on whether this is budget neutral ex ante or ex post, but I think there is still an issue there.

DR. ROWE: Nancy is probably expecting this comment, but I think there are two things about this that are really interesting and important. One is that it begins to migrate from a dialysis program to an end-

stage renal disease program, which is what it's supposed to be, because we're picking up nutrition and -- although that albumin level is a measure of adequacy of management of dialysis patients, it's managed by physicians in many ways. And picking up bone disease and prescriptions for bisphosphonates and vitamin D and calcium monitoring, et cetera, is done by physicians, et cetera, not a dialysis facility, per se.

Although, if you put money in for quality it will give the dialysis facilities incentives to hire nutritionists to spend more time with the patients while they're on the machines making sure their diet is appropriate, et cetera, because the patients are captive there while they're being dialyzed. So I'm interested in that.

I think we should emphasize somewhere in the chapter the business about transitioning from a dialysis program to an end-stage renal disease program and point to the disease management demonstration as another important step there, Nancy.

The second thing I would say, though, is on page 29 you -- I won't use the word admit, that's not

quite fair -- but you indicate that many of these outcomes are influenced or can be influenced by both the doctors and the dialysis facility. But it's not clear to me after that that any of this quality money is going to the doctors. It sounds like it's all going to the dialysis facility.

And I've got to tell you, it's really all about the doctor. I mean, it is really all about having physicians who are understanding that these are very important things and that there are new developments all the time, and they're in touch with the patient. They're getting a capitation fee on a monthly basis already. They've been doing that for years. There's no reason why, vis-a-vis what Alice says, there can't be some additional quality payments in the capitation.

MS. RAY: We will work on the text to make sure it is crystal clear that we are referring to both dialysis facility and the doctors receiving a monthly capitated payment.

MR. HACKBARTH: Should we include that in the bold-faced recommendation?

MS. RAY: We can definitely --

MR. HACKBARTH: I think we ought to include it actually in the language of the bold-faced recommendation, that this applies to both the facility and the physician.

DR. ROWE: You say it on 29 but then you talk about providers. And to be fair, in the context of every other document we've ever seen in this, provider means dialysis facility.

MS. RAY: You're right.

DR. ROWE: So if I were representing the nephrologists, I'd say let's be explicit.

MS. DePARLE: Jack made one of my points, which was about the doctor. I guess in response to Alice's point, and Nancy made this argument herself, I think it is possible to do this. I don't think it's easy to do it, especially when you also involve the doctor. But I said last time and I'll say this time, that I'm a little concerned about doing it on a budget neutral basis given some of the data that -- now I've been sitting here searching for it, Nancy, but I know it's in here, about the GAO report recently about some of the deficiencies in centers and CMS's neglect in

oversight.

MS. RAY: Right. I had mentioned that at the December meeting. GAO issued a report, I think it was in December, that specifically looked at CMS's and state's -- their survey and certification efforts, how well they're inspecting facilities. They found deficiencies in that. However -- and, of course, they suggested that CMS and the states improve upon these quality assurance efforts.

he report also does make note that there has been some improvement since GAO's report prior to this one. So I think that's important to note, too.

And I also think the quality assurance reflects Medicare ensuring minimal standards of care, whereas the incentives as we've laid them out address trying to improve quality of care. Both are important aspects, clearly. And I think there are ways to improve the quality assurance system, for example, having CMS use intermediate sanctions and posting the data on the compare website. MedPAC made recommendations on that. And I think the incentives target a different angle of quality, trying to improve the level and narrow the gap.

MS. DePARLE: I guess I was just surprised, maybe I shouldn't have been. But I was surprised at the level of deficiencies among some of the -- and the percentage of centers that had them. And I don't think we know. I think what you're saying is the oversight may have improved. Frankly, that's a function of the discretionary dollars that the Agency gets for survey and cert, and they have to do annual nursing home surveys and they don't have to do annual dialysis center surveys. It's just that simple.

But given the levels of deficiencies, I just have some concern -- it's a small about, 1 percent of payments. And if we believe that payments are adequate, I suppose it's not that much. But I have a concern about that.

MS. RAPHAEL: I remember in the text that you sent us, Nancy, one thing that surprised me was that margins and cost had no correlation with outcomes. In fact, I think you indicated that the higher the margins, the poorer the outcomes. I'm not sure I got that correct, but could you just explain that because I think it pertains to this issue.

MS. RAY: That was our analysis that we published in our June 2003 report where we looked at outcomes and providers' costs. And there we did not find, with composite rate costs, we found little association between higher costs and outcomes. We found no significant association there.

DR. MILLER: So a facility might argue that they have higher costs but then you're getting higher quality. And that's why we went through this exercise and we can't establish that relationship. That's part of what makes us a little more comfortable with...

MR. HACKBARTH: Why don't you put the first recommendation up? All opposed to the draft recommendation? All in favor? Abstain?

Recommendation two. This will be amended as we discussed to make specific reference to physicians. All opposed? All in favor? Abstain?

Okay, thank you. Next up is Medicare+Choice.

MS. BURKE: Glen, just while people are coming up. In the second recommendation the suggestion was there was no cost implication. I thought I saw a reference in the text that discussed that it might well

have some additional administrative costs. I'm not sure that no is a fair representation.

MR. HACKBARTH: Sheila's making the point that there will be an administrative cost attendant to implementing the quality incentives.

MS. BURKE: Potentially.

MR. HACKBARTH: But we say it has no budgetary effect.

DR. MILLER: Your point is well taken. A lot of what we're doing when we do this -- and this is more technical than we need to get into -- we're looking at benefit baselines. But you're right, conceptually there is an administrative cost.

MS. BURKE: And we ought to at least acknowledge that.

DR. MILLER: I completely agree.

MR. HACKBARTH: Scott and Dan?

DR. HARRISON: The Medicare+Choice program has provided the majority of Medicare beneficiaries a choice of health care delivery systems through private plans. Past MedPAC recommendations have 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 the Medicare Advantage Program for private plans in Medicare. However, much of that program will be based on the Medicare+Choice program. Thus, many of the same issues for M+C will continue to be relevant.

One of the issues we have focused on is setting M+C rates equal to what would be spent on enrollees by the Medicare program if they chose to remain in the traditional fee-for-service program. In the recent legislation, Congress chose to increase payment rates for 2004 and 2005 in order to bolster plans to they would remain in the program until 2006 when some competitive factors would influence rates.

Remember last year payment rates were the maximum of three prongs, a floor rate, blended local national rate, and a minimum 2 percent update. For 2004, a fourth prong is added, 100 percent of the county fee-for-service spending. MedPAC, of course, has been recommending that all county rates be set at that fourth prong. Adding the fourth prong and a few other adjustments, such as restoring IME spending to the

rates, results in M+C rates growing faster relative to fee-for-service spending.

CMS will release the actual payment rates for 2004 this coming Friday but just to give you an idea, I've projected that M+C payments will average at least 107 percent of fee-for-service costs for demographically similar beneficiaries and that's compared with 104 percent the past year in 2003. Those ratios do not take into account any risk selection differences between the plans and the fee-for-service program, and that kind of difference will be discussed shortly.

However, given that Congress raised rates to encourage plan participation and that legislation has also given MedPAC several mandated studies involving broad issues surrounding Medicare Advantage plans, including a study due next year that will give the Commission an opportunity to re-examine financial neutrality. For the short run, including our report chapter and the draft recommendations we discuss today, we are focusing on other issues that are important for the current program and that will also be important in the long run.

I will present three draft recommendations. The first two arise from the new risk-adjustment system that has just been implemented. MedPAC has stated many times that risk adjustment is crucial if we are to pay private, risk-bearing plans properly. Risk-adjustment can be used to help creative financially neutral choices. CMS has made a choice in implementing the new risk-adjustment system this year that has the effect of moving away from financial neutrality and the first draft recommendation would have CMS revert its position in future years.

The new risk-adjustment system also present an opportunity to expand plan choice to the ESRD population 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 quality of plan services.

CMS has implemented a new risk-adjusted system just earlier this month. It measures risk using demographics and diagnoses from inpatient, outpatient and physician settings from the previous year. It will

greatly increase the accuracy of predicted fee-for-service costs for M+C enrollees. And in 2005 a special module will be added specifically for ESRD beneficiaries.

MedPAC has recommended that risk-adjustment systems be developed and used to pay plans fairly, both compared with other plans and with the traditional fee-for-service program. The new risk-adjustment system will increase the accuracy of payments, paying plans closer to the proportion of the expected costs of their actual enrollees.

Thus, plans should be paid fairly compared with competitor plans and should discourage plans from devoting resources attempting to attract a favorable selection of enrollees. However, all plans will be paid more than it would cost the traditional Medicare program to cover the same M+C enrollees because of an upward adjustment that CMS is making for all payment rates. CMS makes this adjustment to equalize total Medicare+Choice payments under the new system with what they would've been under the old demographic system. All plans, regardless of the actual effect that the risk

scores would have on their payments, would benefit from the upward adjustment. This adjustment directly contradicts one of the prime reasons for risk adjustment which was to pay the same to cover a beneficiary whether the beneficiary enrolled in an M+C plan or chose to remain in the traditional fee-for-service plan.

CMS has publicly committed to this policy only through 2004. We do not know what the plan is for future years at this point.

Which leads us to draft recommendation number one. CMS should continue to risk-adjust payments with the new CMS HCC system but should not continue to increase payment rates to offset the overall payment impact of risk adjustment. Because at this point CMS's upward adjustment is not considered current law for 2005, eliminating it would not be considered a change to the current law and that's why we have no spending implications.

Medicare statute states that ESRD beneficiaries are ineligible to join Medicare+Choice plans. However, M+C enrollees who develop ESRD may stay in their current plans. And CMS has exempted ESRD

beneficiaries who have had successful transplants from the prohibition, it deems them eligible to join plans. So at this point, the only ESRD beneficiaries deemed ineligible are those that are receiving dialysis.

Given that the Commission believes all beneficiaries should have equal access to managed care options, and that CMS has developed and will implement a suitable risk-adjuster in 2005, and that we have seen no evidence that quality concerns are greater in managed care plans than in for the fee-for-service for ESRD beneficiaries, we present draft recommendation two, which reiterates a recommendation that we made in 2000. The Congress should allow beneficiaries with end-stage renal disease to enroll in private plans.

One of Medicare's most important goals is to ensure that beneficiaries have access to high-quality health care. Generally, the current payment system is neutral or negative toward quality and fails to financially reward plans or fee-for-service providers who improve quality. MedPAC has recommended that Medicare pursue provider or plan payment differentials to improve quality.

Applying incentives at the health plan level serves several purposes. First, the health plan can use purchasing leverage and data analysis capability to encourage improvement by the providers with which it contracts.

Second, health plans can also address the problem of the lack of coordination and appropriate management of chronic services across settings with patients because they are responsible for all Medicare services.

Measuring quality at the plan level may help identify mechanisms for better coordination and thus imparting lessons and may turn out to be useful in the fee-for-service program, as well.

And to the extent that the plans approaches are successful, providers who treat beneficiaries both in the Medicare private plans and in the fee-for-service program

may learn practices that improve the quality of care for the fee-for-service beneficiaries they treat as well.

In last June's report, we developed criteria for successful implementation of a financial incentive

program. As we noted in June, Medicare+Choice plans meet all those criteria. Standard, credible performance measures are collected on all Medicare+Choice plans. Each year Medicare+choice plans report HEDIS data on specific clinical process measures, for example immunization and screening rates. And they complete a survey called CAHPS that reflects health plan member satisfaction with the plan's service provision. For example, enrollees perceived ability to obtain care in a timely manner.

Together these data comprise a widely accepted broad cross-section of plan quality and most of the measures in the data sets do not require risk adjustment and plans have developed a variety of strategies to improve upon their scores by working with providers and their networks.

Going back a little bit to where we were with Nancy, the goal of an incentives program should be to improve the care for as many beneficiaries as possible. Medicare could reward plans who meet a certain threshold on the relevant performance measure or plan to improve their scores or probably some combination.

In order to create incentives that would improve quality for many beneficiaries, most plans would need to feel that improvement goals were in reach. Thus, we would favor rewarding a large share of plans. The incentives would be financed with a small proportion of total payments, as we just mentioned with dialysis.

What are some of the potential quality measures that could be used? MedPAC uses the quality goals outlined by the Institute of Medicine to determine the level of quality of care provided in any setting. Those are effectiveness, safety, patient centeredness, and timeliness.

As mentioned, Medicare plans already collect such data. These measures could be used in different ways to create the payment incentives. Several of individual CAHPS or HEDIS measures could be used to focus on particular problem areas. The specific measures could change over time to refocus plan efforts.

Individual measures could also be combined to create more comprehensive or composite measures. We don't really want to advocate any particular measures but it is important to include all managed care plans in

the incentive system to maintain a level playing field between plan types and to reward those plans that invested in improving quality.

Incentive programs should thus use performance measures that all plans can collect. All plans, including PPOs and the private fee-for-service plans, report on 12 of the 18 HEDIS clinical quality measures and on all of the CAHPS measures.

However, for use in payment incentives programs, we might favor relying more heavily on the clinical measures of quality collected in HEDIS than on the consumer satisfaction measures in CAHPS. The Medicare payment system does not currently reward strong plan performance on clinical measures, and although they are publicly reported, the HEDIS measures do not tend to influence enrollment decisions. Payment incentives tied to clinical quality measures, however, do have the ability to reward strong plan performance on those measures.

In this draft recommendation MedPAC would not be recommending any particular formulation other than creating a reward pool from a small percentage of plan

payments and redistributing it based on plans' performance attainment and improvement on quality measures. The draft recommendation reads the Congress should establish a quality incentive payment policy for all Medicare Advantage plans.

MR. HACKBARTH: For the benefit of our audience, although we are only considering recommendations for incentive payments in two areas this time around, M+C and ESRD, people should not infer from that that we think that's the end of the task. We see this as the beginning. We think this is a concept that should be broadly applied within the program.

We've chosen the two areas of M+C and dialysis because we think those are the two areas where we're most prepared to move ahead, for all the reasons that Scott and Nancy have described, consensus on measures and the like. But this is not as far as we think these concepts should be applied.

MS. ROSENBLATT: Are we going to discuss all three or one at a time? Do you want me to make comments on all three?

MR. HACKBARTH: Let's just do all three.

MS. ROSENBLATT: Scott, forgive me, I should know this. But I'm getting confused about the years and what you're recommending. The 4.9 percent is going to apply to 2004 or 2005?

DR. HARRISON: [off microphone.] 2005, although that number may change.

MS. ROSENBLATT: And is your recommendation on not making this adjustment for financial neutrality, is that started in 2005 or are you saying we shouldn't do that in 2004?

DR. HARRISON: I think it's a little late to say that for 2004, so we're focusing on 2005.

MS. ROSENBLATT: I think that maybe I'm not the only one that might end up confused by the language. And maybe if you could include that.

DR. ROWE: So it's 2005?

DR. HARRISON: Yes.

MS. ROSENBLATT: So that's my comment on the first one.

On the second one, can you refresh my memory because I remember at previous meetings the advocates for ESRD patients have said don't do this. And I'm

trying to remember why they've said that.

DR. HARRISON: I think it tended to be more from the dialysis facilities than from the groups.

MS. ROSENBLATT: No, I remember advocates.

MS. DePARLE: Alice is right. I met with the advocates a number of times. There was a study going on they wanted to see the results of before they were willing to say it was safe.

DR. HARRISON: And I think we reported the results of that study in June.

MS. DePARLE: I'm going back three or four years.

MS. ROSENBLATT: So the advocates would now say it's okay?

MS. DePARLE: Well, I haven't spoken with them. But what they said then was that they just were concerned that it might not be clinically safe for those patients and they wanted to see the results of this study.

MS. RAY: There was concern raised about the quality of dialysis care in managed care plans versus fee-for-service. CMS implemented a demo, started it

back in the late '90s, '97, '98, finished in 2001. An evaluation was done on it. It included two plans, Kaiser and a plan in Florida, ultimately, Health Options.

The results of that showed that quality was either the same or better in the plans compared with fee-for-service on all the measures except one. The one where there was a difference was on rates of kidney transplantation. And that was with the Florida plan, which was the much smaller plan in the demo. And that was because of the distance from where the plan was to the nearest transplant facility.

But on all the other measures that they looked at -- and again, an outside group did the evaluation -- it was equal to or better.

MS. ROSENBLATT: On the third recommendation I'm still hung up on this, if it was the private sector you'd set up a liability. And I'm just wondering, you all may think I'm crazy, but this is the actuary in me speaking. Do we need some language, maybe not in the recommendation. bit in the text that goes something like this: as the actuaries and the trustees project the

long-range monetary obligations of the program, this quality incentive needs to be considered in the long-range financial projections. That it's not a zero number, that there actually needs to be money included in those projections.

DR. HARRISON: One way we had been thinking about this is you could end up paying on relative rates so that you pay for top X percent of beneficiaries in plans. You stack up all of the scores and pay for the top X percentage, so that you're sure the pot gets paid out. But that was also confusing to people. So we'll work on making it clear.

MS. BURKE: Alice, I would be concerned that that kind of instruction would be translated into new money and that's not, in fact, what's being discussed here. We're talking about a zero sum game. We're not talking about projecting an additional burden on the trust funds, that the actuaries in calculating long-term stability would consider.

MS. ROSENBLATT: I know, but we're not making a comment about budget neutrality. So if they don't include any kind of projection for this --

MS. BURKE: We could say that. I guess I understood when you say set aside 1 percent, that's of the existing pot, that is neutrality. That's not additive money. That's out of the base.

MS. ROSENBLATT: But we don't have that. In other words, I think where it exists right now is if ends up being a half percent, we would be okay with that.

MS. BURKE: That's not my point. My point is it's out of the base; i.e., neutral. Maybe we need to say that explicitly. Whether it's 20 percent set-aside or a 1 percent or a third of a percent, it is out of the base. It's not additive to the base. It's neutral to the base. Maybe we need to say that.

MR. HACKBARTH: And it's our expectation, as we discussed with the ESRD, that it will be paid out as opposed to used as a mechanism to reduce payments.

MS. ROSENBLATT: I'd be a lot more comfortable if we stated budget neutral.

DR. REISCHAUER: Scott, correct me if I'm wrong, because I want to make sure Alice understands this. A 4.9 percent across the board adjustment was

made for 2004 to payments when the new risk adjustment procedures were introduced by an administrative action. We are recommending not just that when the next tranche of risk adjustment is introduced in 2004 that an administrative action is not taken to add another whatever percent to the payment, but that the payment made for 2004 disappears, as it will disappear unless the administration does something.

DR. HARRISON: It doesn't disappear in 2004, it disappears forward.

DR. REISCHAUER: But in 2005 it would disappear.

DR. HARRISON: Right.

DR. REISCHAUER: And there would be no adjustment so we would be back to where we recommended if be.

DR. HARRISON: This adjustment is not published in the base rates. This is done sort of off the books.

DR. ROWE: If we started at $100 and we went to $104.90 for '04, what we would be recommending with this is we go back for '05 to $100.

DR. REISCHAUER: Right.

DR. ROWE: I have comments on each of these. Let's start with the third one. Although I recognize there's a lot of concern among health plans on the quality issue, I believe in pay for performance and I think we're generally trying to go in that direction and I would support that recommendation.

As far as the end-stage renal disease -- and I recognize this is budget neutral, not new money and I would support that as well.

With respect to the end-stage renal disease, I'm not too concerned the advocacy groups, so-called advocacy groups who represent themselves as representing the best interests of the patients. We heard a lot from those groups about how it was really important to do bone marrow transplants for breast cancer patients. And I'd rather see what the data show, but unless the data indicate that there's something wrong with giving dialysis patients the option, I would support the recommendation. As I read it it's voluntary. It's not mandatory. So I don't understand why an advocacy group might -- and you know, you've seen one dialysis patient,

you've seen one dialysis patient. They vary dramatically from healthy young people with polycystic kidney disease to elderly people with many diseases who would benefit disease management programs and other programs that might be in managed care plans.

So it would seem to me that we should let them make that decision. And we might say some stuff about that in the text about the variability of patients and the disease management programs, et cetera.

Now on the first one, a couple points. One is you started with the oft-quoted and sometimes striking statement, Scott, about the payment rates from M+C being, on average, 103 percent of fee-for-service unadjusted and 117 or 113 of whatever it is adjusted. I think it's fair, I liken this to the rural issue. It's a little bit like talking about the payments to all rural hospitals, including the critical access hospitals and the sole community resource hospitals where the rates were increased specifically in order to assure access.

You take those out, then you see that the rates for the rural hospitals don't look as high. The

numbers you gave us include the floor counties, where by law the Medicare+Choice rates were increased above the fee-for-service rates in order to assure access to Medicare+Choice in the floor counties. So I just don't think that's quite fair. I think you should take those out.

You mentioned this in the text but in the presentation that's what we lead with and that's where everybody's starting point is. And everybody therefore says well, these plans are being "overpaid." And I think it's the same thing as with the rural hospitals. It should be apples and apples.

That said, I think we have to then try to figure out whether or not the difference between politics and policy, as a wise person told me recently, whether or not there was a policy reason for holding the plans harmless during the transition or whether it wasn't based on policy. I wasn't there, thank God, but I guess the question is are we confident during the transition in the first implementation of the risk adjustment data and collection and analysis and implementation that something bad isn't going to happen?

Presumably if there was a policy rationale, that was it, to wait until this thing is in place. Does everyone agreed that the data are what they are or are there uncertainties about it?

This is a something I don't know much about but other people do. So I'd like to hear something about our degree of confidence about the implementation of the risk adjustment.

DR. HARRISON: There is a transition built in. This year it's 30 percent based on the risk adjuster. Next year it goes to 50, then 75 and 100. So there is a transition.

DR. ROWE: [off microphone.] I understand the percent that's relative to the risk-adjusted data. I'm just questioning what do we know how that's likely to go?

DR. HARRISON: One of the problems is we don't know. There hasn't been a statement as to why this is being done and how long it would last. There hasn't been a public commitment on the part of the Department to know what their plans are.

DR. ROWE: We are taking a position contrary

to what Congress has recommended and CMS has publicly said they're going to do; right?

DR. HARRISON: CMS has only said they're doing it for '04. That's why we have this problem.

MR. HACKBARTH: We are reiterating a long-standing MedPAC policy of neutrality, and that applies in the case of the floors and all of the other reasons that payments are elevated above fee-for-service levels. I'm not sure I followed your first point on why we ought to not include the floors in the calculation of the relationship between M+C payments and fee-for-service payments.

DR. ROWE: I didn't mean to imply that we shouldn't have included it. I was just trying to get to the point. I mean, if somebody comes up and says rural hospitals are paid more than urban hospitals why X percent, then somebody says wait a minute, that includes these special hospitals where there was limited access. And so they did that for a reason. And I think it's the same thing with respect to some of these floor four counties. So I'd just like that included in the conversation.

MR. HACKBARTH: So what we're doing here is we've increased the fee-for-service payments for rural providers, elevating the Medicare fee-for-service levels in the rural areas. And then we're saying on top of that we are going to add still more money for private plans. That's the policy that's in effect and that's the policy that we're taking issue with.

DR. REISCHAUER: But Jack is suggesting that the reason for the floors is to guarantee access for all Medicare patients to Medicare+Choice plans. And I think that was the original intent, but we have to remember that this system, in a sense, has run amuck when you go to Denver and you say that Denver County is a floor county. I mean, I do believe that there are Medicare+Choice plans in Denver, at least there were when we were thinking of it as a site for an experimentation because there was so much competition in the area.

MS. BURKE: Just two questions on the actual text. At the very beginning of the document you briefly referenced the creation of the new Medicare Advantage, or whatever it's called. I wonder if some fuller

explanation of how these differ from the Medicare+Choice, because you suggest that they're establishing a new program called MA, and that the MAs are similar based on the rules and payment structure in M+C, and M+C would become MAs.

For the ill-informed, some further explanation as to is there really a difference or what the critical differences are between what was and what will become might be helpful.

DR. HARRISON: I don't think there's really much of a difference except that they add the regional plans.

MS. BURKE: I think a little further explanation for people who haven't followed this closely might be useful.

The thing I think that might be helpful in terms of background information, the one chart that is not included is the number of plans currently in the program. You have the withdrawals and how many people they affected. You don't have the number of plans referenced, which the number of people is obviously more critical. But there's also nothing in here, even though

you talk about the availability within certain areas, you don't ever anywhere talk about how many plans there actually are and how that has moved around, at least not in the document I saw.

And I just thought for a fact, that might be useful background to just have what the trends have been and the distribution among the types of plans. You referenced that in the content, in terms of how they have changed but an actual chart that says how many there are, how that's changed, and what the distribution is across the types of plans might be useful as background information.

MS. ROSENBLATT: Sheila, by plan do you mean entity or do you mean like if one company offers five plans it would be a count of five? Or would that be a count of one for one company?

MS. BURKE: It would be a count of five. I want to know how many plans are in play. If there are 5 million people enrolled, in how many plans are they enrolled?

MS. ROSENBLATT: I would ask, I think both might be helpful because you might offer five plans but

nobody takes four of them.

MS. BURKE: [off microphone.] I can't look at this and say this many we talked about it. There's nothing that references how many there are, how that's changed and the nature against the types of plans.

DR. HARRISON: There's a problem with data in that we know the only numbers that have been consistent over the years have been the number of contracts which is really a very tough measure of what --

DR. MILLER: Scott, just using the same metric that we use to talk about plans dropping enrollment, we will use that same metric to talk about what plans are present and what the enrollment is.

DR. HARRISON: Yes, I have current information. It's going back that's tougher.

MS. BURKE: [off microphone] Whatever we have that's reliable in any way that is the least confusing, but it's an obvious question that arises in the text and there's no place where you actually figure out how many of whatever is in play. But that in terms of -- and also the explanation of [inaudible].

DR. NELSON: I agree with the recommendations

and basic principles. My comments are more second level of detail.

I know we don't point out typos but occasionally there will be a clinical reference that I don't want to fall through the cracks and have us look clinically ignorant. So on page 13 it references hemoglobin levels for diabetes, and obviously mean hemoglobin A1c levels. And I point that out just so it won't somehow make it into the final report.

My main comment has to do with the administrative burden, the hassle that comes from abstracting information from records in PPOs or private fee-for-service. You point that out on page 14 and you point it out properly. But until we have an electronic health record, it's really important for everybody to recognize that simply rewarding these measures without considering the cost in time and money to collect the information and the fact that sometimes it's buried way down in the chart where it's hard to find, the point really needs to be borne in mind.

With respect to that, on table three, somebody makes an allocation of which of these HEDIS reporting

data are applicable to private fee-for-service and PPOs and which ones aren't. And a number of those are arguable either way. For example: colorectal cancer screening might be applicable because you have colonoscopy and occult blood screening on administrative data sets.

DR. HARRISON: This table is actually from the Medicare managed care plan manual and this tells the plant what they're responsible for. So indeed, PPOs and private fee-for-service do report on the colorectal cancer screening. Now actually, that one turns out to be a new measure that they will have to start reporting this year. So these are decisions that CMS has made in administering the program.

DR. NELSON: Good. So that it doesn't become arguable and attributable to us in that argument, let's make sure that that's referenced.

DR. HARRISON: Let's make sure that that's clear.

MS. DePARLE: Sheila's question reminded me of a question I had when I read your materials. On page five you talk about the private fee-for-service plans

and the reductions in those over the last couple of years. And I was curious as to what we think is going on there.

And then also you talk about the PPO demo. It doesn't say in here but the goals of that obviously were to expand access to these kind of plans. I can't tell from this whether any of those demos have gone into places where there were not already some sort of M+C options.

DR. HARRISON: The answer is some but not many.

MS. DePARLE: So how many?

DR. HARRISON: I did that a few months back. My recollection is -- I don't remember. I think it was single digits but I don't remember.

MR. HACKBARTH: Do you remember, Scott, the percentage of the PPO enrollees that were previously enrolled?

DR. HARRISON: Yes, that's in here.

MS. DePARLE: That's in here. That's 51 percent.

DR. HARRISON: There are some areas where

there wasn't a Medicare HMO where a PPOs went.

MS. DePARLE: That's what I'm more interested in because if we want to get coverage of this in an option for beneficiaries, if not why not? Maybe Jack or others can answer, why are they still not going in there? Are there other things that we need to be doing?

And on private fee-for-service, I'm surprised that that seems to be declining and I'm interested in any insights you have about why that's happening.

DR. HARRISON: My impression is they see their history in an area. And if it doesn't look too good, they get out. New plans, but I'm saying the one plan tends to look at areas and see how they're doing.

MS. DePARLE: Loss ratios?

DR. HARRISON: I'm sure that's what they must doing.

DR. MILLER: [off microphone] Also no involvement.

DR. HARRISON: Well, their low enrollment sort of generally. They have a very vast area and a no area is their really large enrollment.

MS. DePARLE: Does it appear that there's any

relationship between the PPO demo and the retrenchment of private fee-for-service? Because one could argue there's similarities in what those two kinds of offerings would be doing.

DR. HARRISON: I don't think so.

MS. ROSENBLATT: Scott, given Bob's comments, I need some additional clarification. It's been pointed out to me that there's report language in the Balanced Budget Refinement Act of 1999 which reads as follows: the parties to the agreement urge the Secretary to revise the regulations implementing the risk-adjuster so as to provide for more accurate payments without reducing overall Medicare+Choice payments.

I don't know what that means, and for how many years that was intended or whatever. I've just been given that one sentence sort of out of context.

DR. HARRISON: I'm glad you found it because I thought it was in BIPA. I couldn't find it last night. So it's BBRA?

DR. REISCHAUER: That sounds like report language. That isn't legislative language at all. So

it's sort of like don't complain to me when I vote for this.

MS. ROSENBLATT: It was told to me that it was report language, yes.

DR. HARRISON: What happened was originally risk-adjustment was put in place. CBO, not knowing exactly what was going into place, was reluctant to say that there were any savings to it. So when it came back with a zero score, Congress looked at it and said oh, so you mean it's budget neutral? And then they put budget neutral into the next report language. There were questions about what the actual intent were and there were two schools of thought about what the actual intent was.

DR. WOLTER: I'm quite supportive of the recommendation on the quality incentive, but a couple observations. In my review of the HEDIS criteria, I would say that's a pretty low bar in terms of specifically the clinical quality indicators. Particularly when you combine that with a recommendation of collecting only what all plans normally collect, you further even eliminate a couple of the clinical quality

indicators.

Looking ahead beyond this year into next year, a few observations. I'm less optimistic than the chapter would suggest that health plans will be good at coordinating care because they're responsible for all Medicare services. They're responsible for payment of all Medicare services, but particularly plans that primarily have panels made up of independent practitioners may have less leverage than, for example, Kaiser Permanente or other staff model plans.

Also, I would note that some of those plans, Kaiser in particular, are making huge investments in clinical information systems which may allow us to have more immediate availability of the clinical quality indicators.

The other thing I would say is that actually in the fee-for-service system, CMS right now through the QIOs is measuring a more robust number of quality indicators than you would find in HEDIS. And in fact, in the recent law we now have .4 percent of Medicare payment actually tied to volunteer reporting of some of those.

So there's kind of a lot happening all at once right now and we might want to have our eye on how some of these things could be brought into alignment as we look at our quality agenda at MedPAC over the next year or two.

For example, since many providers are going to be capturing these measures anyway because of voluntary reporting or QIOs, perhaps plans should look at their quality agenda or we should be recommending HEDIS move to including some of those same measures so that over time we can compare plans with fee-for-service.

MR. DURENBERGER: First, I think this is an excellent piece of work and an excellent start on a subject that we're going be deeply involved in, much more deeply involved in, in the future and so I thank the staff for that.

Secondly, I very much want to associate myself with Nick's remarks, and particularly that a plan is not a plan is not a plan. But take it another step farther and particularly my first question mark as I was going through this was in the very first paragraph. And I know the subject here is Medicare+Choice. It's not

docs, but it says Medicare has a strong history of supporting private plans. The Commission strongly believes that beneficiaries should be given the choice of delivery systems that private plans can provide. Private plans have a greater flexibility to innovate, et cetera.

The implication is that you can't get a choice of delivery system except through a plan. At least that's one. And the second one is that plans have some unique flexibility to innovate that provider groups in particular do not. And that's not true.

You can go to Nick's practice group. You can go to very large groups in North Dakota. You can go to groups in Minnesota, Wisconsin, all over the country, and you can find doctor groups who have done a lot of investment in innovation, a lot of investment in quality, and they haven't been rewarded for it because the Part B system doesn't have a mechanism for doing that.

So when we express ourselves in the context of treating fee-for-service equal with private plans, et cetera, I think we have to take it a step beyond that.

And part of what Nick said relates to that and part of what I'm trying to say relative to this introduction language is also important to say.

That is that groups of physicians, groups of physicians and hospitals, systems like the one Nick runs, which is a hospital systems but it's basically run by a group of docks, but they run a hospital in a huge service area, have traditionally done a lot of the things that we are now turning nationally to Medicare+Choice plans to try to achieve.

And I think each time we try to say MedPAC supports this or that or we're fostering a particular approach, we really do need to reflect the fact that the system has failed, at least the payment system in the past, has failed to reward a lot of docs and doc groups in the fee-for-service system.

MR. HACKBARTH: I think that's an excellent point and we need to treat the language. The benefit of the M+C payment system is that it's a payment mechanism that maximizes the flexibility of clinicians, provider organizations to allocate resources new ways. Whereas, the traditional fee-for-service payment system with its

silos can sometimes get in the way. Despite the fact that the fee-for-service payment system gets in the way, there are physician groups and provider organizations who do it anyhow. We ought to knowledge that that does happen.

DR. REISCHAUER: I was just going to say, I think this involves more tweaking than restructuring. All you've said is that it's greater flexibility, not that the others don't have any flexibility. And what you probably want to say is on some dimensions, private plans have greater flexibility. And then the list of areas that you cited, some of those I think Dave right would say, hey, a good practice group in Minnesota can do that, too. But sort of the breadth of the benefit package, financial services, some things like that, the traditional fee-for-service system really doesn't offer any ability to experiment or provide flexibility.

MS. RAPHAEL: Just to build on Nick's point, I've recently been involved in a group working with Kaiser and Group Health and others looking at this care coordination and coronation across sites. And there's just a lot of road to travel here. And I would like to

see looking at some outcomes that would measuring, in fact, coordinating care across sites rather than again just what you do within each of the components of the providers that comprise the plan here. Because I think until we begin to measure this, we're not going to see movements even though plans ostensibly have more of an incentive and they have control of the entire Medicare dollar.

And then the other point, I see this as a triangle with Congress, the plans, and the third angle has to do with CMS. I don't think we're going to succeed in this quality incentive area if CMS doesn't build an infrastructure and change some of how it looks at what it is responsible for.

I think we need to mention that in the text because I think often something is passed and then lo and behold we think about how is this all going to come to pass.

I think there are some elements going on now in CMS that can be built upon, but I think we need to make that point ultimately for this area, for the ESRD area, there has to be some attention paid to what's

going to happen in CMS.

MR. MULLER: To go back to Scott, your first estimate I think when you started this, that you think that the plans will be now be paid roughly 107 percent of fee-for-service. Did I hear you correctly on that, Scott?

DR. HARRISON: Yes.

MR. MULLER: And where we have some evidence in the text that there's been some abatement in the dropping, or at least the dropping of M+C enrollment has dampened a bit, and in fact may have gone up by 1.5 or 2 percent in the last year or so; correct?

DR. HARRISON: Yes.

MR. MULLER: But if we have a payment plan in which we're 103, 105, 107 percent above fee-for-service, and we still don't have a major increase in enrollment, one of the questions I have is how much is it going to take to get enrollment back up? With a 7 percent premium already, and I know some of that 7 percent is perspective, but we've had more than 100 percent payment the last few years and we've only had modest increases.

What will it take to get -- insofar as there's

a philosophical preference, at least as expressed in the most recent legislation, for getting more people into payment plans, whether it's flexibility or other kind of reasons that the authors of the bill wanted, it's still a fairly significant premium in light of all the payment pressures inside the program.

I don't know whether we or anybody is yet speculating as to what the increase might be. I remember when Mr. Scully first came in, he was looking to get M+C up to somewhere in the 30 or 40 percent range. And obviously it went the other way for a while, up to the recent abatement.

So I think one of the things we need to be looking at, and I don't think it's part of our mandate to speculate as to what it's going to take to get this kind of increase. But certainly the evidence has been that the payment increases have not brought the increase in participation that people are looking for.

MR. HACKBARTH: I'm not sure that there's any gain in our speculating about what the magic price might be. There are a lot of factors at work in the market here. I think a lot of Medicare beneficiaries were

stung either personally or heard of other people who were stung by plan withdrawals. And it takes time for people to get over that. All of the bad publicity that managed care received in the 1990s, much of it if not most of it unwarranted in my opinion, affects public perceptions and affects enrollment rates. Lord knows what the number is.

I think that's irrelevant. I think what's important is the principle of neutrality. I strongly believe, for a variety of reasons, that having this as an option for Medicare beneficiaries is very important. Jack gave us an illustration in the case of patients with ESRD about the potential gains of being in a private plan that has the flexibility to do some different things. I believe that's true not just for ESRD patients but for many other patients. I am a true believer.

Having said that, I think it's critically important that we be neutral. And I really don't care what the right price is --

MR. MULLER: You misread my -- I'm in favor of neutrality, too. We're paying a big premium to get

people in that goes well beyond neutrality.

MR. HACKBARTH: Let's be neutral and let the chips fall where they may. The beneficiaries will make their choices. Personally, I take a long-term view of this. I think for a variety of reasons right now many Medicare beneficiaries are discouraged about private options. I think that will change in time. I hope it changes in time because I believe it will be good for them if the attitudes change.

DR. ROWE: Just one reaction. Those of us in this industry are delighted that you're a true believer, Glen. It sounds like you've drunk the Kool-Aid. It doesn't sound like you're willing to pay for it, but it does sound like you've drunk it.

[Laughter.]

DR. ROWE: I guess one thing I would say in response to Ralph's question is that I think one way to look at -- I don't know what the number is. That's not worth thinking about too much.

But it is worth thinking about the floor counties versus the others, or the rural areas versus the others. Because what happens is Medicare determines

what the payment rate is for the providers and the health plans negotiate. And in areas in which there are thin networks, providers and hospitals, that drives up the rates that those providers can charge and you wind up with much higher than what the Medicare fee-for-service payments are.

So that's like a whole bunch and if the philosophy in Congress or CMS or in this room or wherever is we want everybody in America who's a Medicare beneficiary to try to access to a plan, that one of the things that drives the numbers up. It's those floor counties and the thin networks and the marketplace. And I think that's what Glen was referring to when he said there are a lot of market factors.

It's not a homogenous thing. It's very, very different in large urban areas where there are overlapping networks and Medicare payment rates are more or less similar to what the plans might pay the doctors.

So I think that's just one issue to consider.

MR. HACKBARTH: I think you're characterizing the reasons that people support these things accurately. I believe it is because they do think that everybody

having access would be a good thing. And they think the price lever is one lever that we can use to try to stabilize enrollment and broaden plan participation. I understand that. I respect that. But I do disagree with it. I think it's a mistake for the program.

We need to move ahead with our votes. Do you want to flash up our recommendations?

On draft recommendation one, all those opposed?

MR. FEEZOR: [off microphone.] Question, this is going to continue beyond 2004?

DR. MILLER: [off microphone] We're trying to capture that with a should not continue.

MR. SMITH: [off microphone] I was troubled by that language because it suggests there's another payment increase in the offing. But what Bob was saying is this payment should not continue. So I think we need to reword.

MR. HACKBARTH: Does people understand the intent here? All opposed? All in favor? Abstain?

Number two, all opposed? All in favor? Abstain?

Number three, all opposed? All in favor? Abstain?

Okay, thank you.

We'll now have a brief public comment period. Please, as usual, keep your comments very brief. And if someone ahead of you in line has made your comment already, please don't feel obliged to repeat it.

MR. HAKIM: Mr. Chairman, my name is Ray Hakim. I'm a nephrologist and also the Chief Medical Officer for Renal Care Group, a dialysis provider. My comments relate to the dialysis provision.

We very much appreciate the Commission's and the staff's noting that we have improved outcomes in certain areas, as Dr. Rowe has mentioned. They are specifically in the dialysis program and not in the ESRD program. But we appreciate that mention.

What perhaps may be important for the Commissioners to realize is that this program has a mortality rate of 25 percent. When I walk into the dialysis unit, and when Jack Rowe was a famous nephrologist, gainfully employed as a nephrologist, every time I walk into the dialysis unit I know that a

year from now 25 percent of the patients will not be there. And the issues related to that have been touched on by a number of factors.

Clearly, it's not only high, it's higher than breast cancer, colon cancer. And more importantly, the mortality rate for the dialysis program in the United States is much higher, between 50 and 100 percent higher than it is in other industrialized countries.

So we have to ask ourselves what it is that we here are doing or not doing. I agree with you that attention to nutrition, attention to access factors, and hopefully pre-ESRD, are issues that the Commissioners will focus on.

But to think that this is going to be happening in a budget neutral is illusory, because the presentation by the staff that Medicare provider or Medicare patients have a 2.7 percent margin is simply not sustainable in our opinion. And we have presented data to the staff about that.

The 2.7 percent margin has a 4 percent audit factor established in 1996 and is nowhere representative of the audits that we believe is important. I will

stand here next to you and apologize to the staff if there is anywhere near 1 percent audit factor, let alone 4 percent. That's one issue.

The other issue is that this 2.7 percent is based on cost reports that have limitations that have not been addressed by the staff despite our recommendations and suggestions to them. It has limitations established in 1983 for medical director fees, for administrative fees that simply are not reflective of the true costs.

Third, there is also an implication that we can improve efficiency and productivity. I will tell you that there is probably a way in which we can improve productivity. Right now we have one nurse for 12 patients. I suspect back in the office somebody is calculating already can we do it one nurse for 15 patients. We have one dietitian for 100 patients. Somebody is going to figured out maybe we can do one dietitian for 125, 150 patients. So who's going to suffer in that? It's the patients that are entrusted to our care.

I would urge the Commission to really ask the

staff to focus on the audit factors, on this productivity issue, and the true cost of providing care because -- and I'm glad Dr. Rowe is back here -- we are, and we have shown data, we are losing money on every time we dialyze a Medicare patients when we include drugs and everything else. And we have shown that data to the MedPAC staff.

So I would urge the Commissioners to really again challenged the staff to come up with a true audit factor, a true efficiency factor, and a true cost report factor.

Thank you.

MR. CHIANCHIANO: I'm Dolph Chianchiano with the National Kidney Foundation.

I wanted to respond to Sheila Burke's question about home dialysis patients and indicate that there have been dramatic increases in quality indicators for PD patients. We'd like to think that has to do somewhat with the National Kidney Foundation practice guidelines. From 1999 to 2002 there was an increase in the percent of patients meeting the National Kidney Foundation guidelines for weekly adequacy for dialysis. For CAPD

patients it increased from 55 percent to 68 percent and there are similar patterns for cycler patients.

I also wanted to address some of the comments from Dr. Rowe about managed care plans and dialysis patients and I wanted to explain why dialysis patients, ESRD patients, remain skeptical about managed care. One of the recent developments which I would like to bring to your attention has to do with changes in copayments that managed care plans have imposed. there was one managed care plan that attempted to establish a $50 per dialysis treatment copayment a couple of years ago. That would mean $150 a week out-of-pocket for a dialysis patient which would be impossible for most dialysis patients.

The other concern is also financial, and that is if a dialysis patient decides that they no longer want to participate in a managed care plan, they will not be able to get Medigap insurance to assist them in their payment for their costs.

And then finally, with respect to the demonstration project that Nancy referenced, take a good look at the patient profile of those patients. And

also, I might note that one of the two plans that participated was Kaiser and, which of course has a staff model and it might not be applicable to the care of end-stage renal disease patients in other managed care plans.

Thank you.

MS. ZUMWALT: My name is LeeAnn Zumwalt. I'm with DaVita, a national dialysis provider.

I wanted to be brief and support the comments of Ray Hakim as to our economics. I wanted to directly answer Dr. Rowe's question. The private sector does, in fact, supplement and support the Medicare program.

On the access to care issues, we have provided data to Nancy and to Mark Miller that says yes, in fact, we are growing. But the data says where the growth is is where the private patients are. We are not growing in areas where Medicare is expanding and we're not introducing new capital into areas that are predominantly Medicare/Medicaid patient-oriented areas.

Thank you.

MR. JOHNSON: Good afternoon, Seth Johnson with the American Association for Home Care. Appreciate

the ability to provide comments prior to the Commission voting on recommending payment changes to the home health benefit later this afternoon.

We urge the Commission to further study the impact of the changes that have been occurring both legislatively and regulatory-wise since the 2002 data that is now widely available has been released.

We know that there's been some suggestions today about the reliability of the data that is currently available and we believe certainly that is the case for the home health data that the Commission and the industry and other government entities have been looking at.

The industry did look at the profitability of the Medicare home health benefit and it showed a profitability of just over 5 percent based on 2002 cost report information. The CMS home health market update, looking at the profitability of the publicly traded companies showed a 2.3 percent profit margin for the home health industry.

We do know, based on the Commission's staff, that over 1 million Medicare home health beneficiaries

are no longer receiving care that were receiving care and that substitution is occurring. There's a lot of changes that are occurring within the home health benefit and the industry doesn't have all of the answers, and I don't think anybody has all of the answers as to what is truly occurring due to the issues surrounding the availability of data that's reliable and taking into account all the legislative and regulatory changes that have been occurring.

We urge the Commission to not make any additional changes to the Medicare home health reimbursement prior to doing a complete and thorough analysis of reliable cost report information.

Thank you.

MR. AUGUSTINE: My name is Brady Augustine and I work as a senior advisor for the Administrator at CMS. I'm also the senior person at the Agency for ESRD.

Dr. Rowe, I want to thank you for your comments. I think the program has gotten away from its intended purpose from 1973, and we're trying to bring it back. We've taken a lot of activities, one example given today is the disease management demonstration

project. Another one is in the recent statute, it takes away the incentive to overutilize the separately billable drugs.

So we want to take a more holistic approach to care. A lot of the quality activities that are underway presently in the dialysis industry are those for which profit margins could be increased; i.e., anemia with the use of Epogen. So we're trying to take away that incentive to overutilize separately billables.

As well, we have also -- one of the reasons why there hasn't been really good coordination in holistic care for these patients is because all the payment systems are not aligned. For instance, as you referred to earlier, Dr. Rowe, the MCP -- and being an old managed care person, any time you come up with a capitation system where there are no accountability requirements, it is potentially going to be abused. Between the OIG and the GAO reports that we've received, and also patient input into the Agency, the Agency decided to make a change in the MCP and to require physicians at least for in-center patients to see their patients and provide a comprehensive assessment monthly

in order to get paid by the Agency.

So we're trying to get physicians involved. We're trying to get facilities more involved. We have this core court dataset initiative where I will admit the industry has been quite helpful with the Agency in submitting data to us on 100 percent of their patients. As opposed to right now we just get a 5 percent sample for the clinical performance measures project.

So we're looking to expand the data that we get. We of course, are interested in outcomes-based reimbursement for this program. And it doesn't necessarily have to be before the fact. It could be after the fact, depending on the evidence. For example, with vascular access, there's such strong evidence that proper vascular access care will lead to reduced hospitalizations that depending on the evidence and how we look at it, I would not have a problem paying above what they're currently getting as long as we have the evidence to show that we know there will be reduced hospitalizations and will pay for itself.

So there are a lot of ideas bouncing around the Agency. We're very interested in outcomes

reimbursement and getting everyone's payment system aligned so that physicians and facilities are all working toward the goal, which is patient-centered care.

Thank you.

MR. HACKBARTH: We will reconvene at 1:15.

[Whereupon, at 12:24 p.m., the meeting was recessed, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION [1:23 p.m.]

MR. HACKBARTH: Next on our agenda is the payment update for physician services. Cristina, Kevin whenever you're ready.

MS. BOCCUTI: Thank you. Our presentation will be very quick today and it draws mostly on information that Kevin and I presented to you last month. Since we only have about five slides I'm going to run through all of them but Kevin and I are both here to answer your questions when I'm done.

Before presenting the draft recommendation and as a backup I'm going to first mention some provisions in the new Medicare legislation which affect payments for physician services. Then I'll briefly review the information we presented in last month's meeting on payment adequacy for physician services and expected cost increases for 2005. Finally, the draft recommendation will be presented for your discussion.

So the first question you might have when you see this slide is DIMA. This is what we're using now for the Medicare Prescription Drug Improvement and Modernization Act of 2003. I think that the acronym is

still in development but for today were using DIMA. Other terms you might have heard are MPDIMA and MMA for short, just the Medicare Modernization Act. So if you hear them, we're all talking about the same thing.

So as you know, the new Medicare legislation includes an update for physician services of 1.5 percent for 2004 and 2005. This is going to be accomplished by increases in the conversion factor. In addition to this provision there are several others that will increase payments for services furnished by fee-for-service physicians.

The first one I'll talk about is the GPCI floor. This is newly established in the legislation as a floor of 1.0 for the work component of the fee schedule's GPCI. So effectively this floor ends up raising payments for services in areas with below average costs of the work component.

Then the next is the scarcity bonus. Services provided by physicians in newly-established scarcity areas are going to receive a 5 percent bonus payment. These scarcity areas are established separately for primary care physicians and for specialist.

The third bullet there talks about a pre-existing 10 percent bonus payment to physicians that are practicing in health professional shortage areas. Under the new legislation the responsibility for identifying eligibility for the bonus will be shifted from the physician to the Secretary, so that the payments will become more automatic.

Finally, in Alaska all three GPCIs, that's the work, the practice expense and the PLI GPCI will increase to 1.67.

MR. DeBUSK: In the scarcity area bonus of 5 percent for primary care physicians and specialists, will that include PAs and nurse practitioners as well?

MS. BOCCUTI: It's for the service. I think that determining where it occurs was based on physicians. So the bonus gets attached to the service provided, but the areas are determined -- I think that the determination was based on a ratio between the physician and beneficiaries.

DR. HAYES: That's correct. I'm not 100 percent sure about whether nurse practitioners and physician assistants are eligible for this thing or not.

I just don't recall from the legislation. We can get back to you on that.

MR. DeBUSK: I can hardly see how they could exclude them.

MS. BOCCUTI: We'll look at that. I think that the health professional shortage areas might have more latitude, but that's a good question. I'll continue on.

As you know, MedPAC's framework for assessing payment adequacy for physician services relies on indicators of beneficiary access to physicians and physician willingness to serve Medicare beneficiaries. We draw on these indicators, among others, because physicians don't report their costs to Medicare as do other providers such as hospitals.

So I'll first talk about access. As we talked last month and as we presented then in the last meeting, survey data from 2002 and 2003 indicate that on a national level beneficiaries have good access to physicians and most beneficiaries are able to find a new physician and schedule timely appointments. For example, the largest survey that I presented last time

found that 90 percent of beneficiaries reported that they were always or usually able to get doctor appointments as soon as they wanted. But a small share of beneficiaries report that they experience difficulties getting appointments and finding physicians.

In 2003, CMS sponsored a beneficiary targeted particularly in areas where they thought beneficiaries were most likely to have access problems. Unfortunately, the study has not yet been released to the public but we'll try to keep you updated on the results of this study as possible.

The next bullet on the physicians supply up there, the number of physicians practicing in the U.S. has increased faster than both the general population and the Medicare population. As we mentioned in last month's meeting, survey data suggest that most physicians are willing to accept new Medicare beneficiaries but some do not. For example, the National Ambulatory Medical Care Survey found that 93 percent of physicians with at least 10 percent of their practice revenue coming from Medicare accepted new

Medicare patients.

As Kevin discussed in last month's meeting, our examination of claims data through 2002 show that the volume of physician services has continued to grow steadily over several years and the steadiness of this increase does not on its own indicated inadequate payments. As you should recall also from last meeting results from research sponsored by MedPAC show that the difference between Medicare and private sector payment rates, those payments widened slightly in 2002, a couple percentage points. The driving force was likely the 5.4 percent cut in the fee schedule's conversion factor in 2002.

So the second part of our adequacy framework looks at changes in cost for 2005. CMS estimates an increase in input prices of 3.4 percent in 2005, which is 2/10ths of a percentage point higher than its estimate last quarter. The other factor that we consider in our update analysis is productivity growth. Our analysis of trends in multifactor productivity suggests a goal of 0.9 percent.

So with all this in mind here again is the

draft recommendation for your consideration. It's the same as we presented in the last meeting. The recommendation would update payments for physician services by 2.5 percent for 2005. This recommendation would maintain current beneficiary access to physician care and current physician supply for Medicare patients. Our estimate indicates that this recommendation would increase Medicare spending by somewhere between $200 million and $600 million relative to current law.

That concludes my presentation so we can discuss it now.

DR. ROWE: On the proportion of the physicians who are involved in the Medicare program you said it was 93 percent of physicians with more than 10 percent of their patient revenues coming from Medicare were not accepting new patients.

MS. BOCCUTI: Are accepting.

DR. ROWE: Were accepting; 7 percent weren't. That could mean that they're too busy to accept any new patients whether they're Medicare or not, or it could mean that they're dissatisfied with the Medicare rates. What percent of physicians do not participate at all in

Medicare who used to participate? That is, not the pediatricians or obstetricians but people who actually did participate and have dropped out.

MS. BOCCUTI: Let be clarify. Do you mean the participation rate or actually seeing Medicare patients? Because the participation rate is something where they sign up and officially become a participant which has some other value added to that.

DR. ROWE: Let me tell me why I'm asking and then you can tell me which question to ask.

When there was a 5.4 percent reduction in the physician payments we heard, hell, no, we won't go. That we're going to withdraw from the Medicare program and there's going to be a flight of physicians and there won't be access, et cetera. So I'm trying to understand whether or not there was. So that's my question, and I'm not sure which of your subquestions that --

MS. BOCCUTI: I think I do. There was even an issue when the cuts were scheduled that physicians were saying, we're going to stop participating. CMS is extending the time period when physicians could say whether they're going to participate or not up until

February of this year. I think it's all related to the conversion factor which was slated to decrease and now is going to increase.

Now our analysis of the participation rates, those are physicians who sign up to participate with Medicare and thus can have a 5 percent -- their payments per serve are 5 percent higher than those who are non-participating. That rate has increased every year and it's at about 93 percent I think this year, or 91 percent in 2003 and it has not dropped over the last few years. It's in the draft chapter. I'm going to find it for you.

DR. ROWE: What I'm trying to do and I'm not doing it well is I'm trying to ask a multiple choice question, not an essay question. How about if we pose it this way? Do we have any evidence from the various forms of participation that there has been any significant withdrawal of physicians from the Medicare program?

MS. BOCCUTI: Kevin wants to give it a shot.

DR. HAYES: We confronted that issue.

DR. ROWE: This is a yes/no question.

DR. HAYES: Then the answer is no. But let me elaborate, if I may. I could elaborate a little bit but if no is okay, maybe we'll just --

DR. ROWE: No, I don't want to take everybody's time.

MS. BOCCUTI: Maybe we should just say when we're looking at this on a national level.

DR. ROWE: Thank you.

DR. WOLTER: Just a question, in a table in the body of the report, Table 3.b.3, if I'm interpreting this right, the change in physician services per beneficiary from year to year is basically a dollar number because we're taking the RVUs and multiplying by the conversion factor?

DR. HAYES: That's right.

DR. WOLTER: I'm wondering if it would also have value to look at the change in actual units from year to year, how many echocardiograms, how many CT scans, because obviously some of them weight higher and the dollar changes when it gets converted into a, percentage. That might look differently than if we just looked at the absolute numbers.

DR. HAYES: When we've done this kind of analysis in the past we have often included the units change as well. As you can see from this table it's already got quite a few numbers in it so that's why we chose not to. The other reason we chose not to in this case was because we have found that the units changes tend to be very similar to the changes that you see in this table.

DR. MILLER: But we can put it in if you'd like to see it.

DR. NEWHOUSE: Is it the all-services number in that category that total the increase in RVUs? Does that include the conversion factor change? about.

DR. MILLER: No, Nick is asking for just the unit count, the number of services and what those columns represent.

DR. REISCHAUER: The number of office visits as opposed to the complexity.

MR. SMITH: Kevin, is the answer to Nick's question that the average annual percentage change column is a proxy for the number of units? That it's very close?

DR. HAYES: It's similar to the number of units, but it's weighted. The particular percentages that you see in this table is weighted also by the relative value units from the fee schedule. So it captures not just the change in units but also any change in the intensity of services that's provided.

MR. HACKBARTH: Any other questions or comments?

MS. BURKE: Can I just ask for a clarification on that? Does that suggest in the extreme that you could have had -- showing a 9.4 percent change in echo solely as a result of the intensity and not as a result of the actual volume?

DR. HAYES: In the extreme, that is the case. But as I pointed out to Nick, when we've looked at these kinds of changes in the past we've seen some close similarities between the number of units and the kind of measure that you see here. But there's always the possibility of the extreme case that you're talking about.

MS. BURKE: We have no way to look at this and know where it was largely volume as compared to

intensity?

DR. HAYES: The way to do that would be what Mark was suggesting which is to put both numbers on the table so you can do the mental subtraction one from the other and figure out what's the intensity change.

DR. NEWHOUSE: I'm not following this, what the table is then, because I would have thought that, for example, when I look at imaging change 9.4 percent between 2001 and 2002 that that was the increase in RVUs for imaging. Then when we get down to a specific thing like advanced CAT scan of the head 5.3 percent, I would have assumed that was essentially almost all volume because that's so specific. So I'm not sure what we need that isn't in the table.

DR. MILLER: Both of your comments are correct. That's why the actual raw volume count tracks to this very closely because when you get down to this level of disaggregation you are almost on a one-to-one basis. But it really wouldn't kill us, we could put the raw volume counts in with it. Just as long as everybody is tracking this, you could count office visits and that would be a straight measure of volume, or if more

complex offices visits were done, longer or whatever the case may be, that could also drive this number up. That's sort of volume and intensity. But they track very closely I think is the point.

MS. BURKE: I understand what you're saying. I'm trying to think of the implications for us in greater clarity. It would seem that the implications would simply be raising the flag if there were disproportionate increases in volume of certain kinds of activities that would then lead us to look at what is it about that activity. Its it that there's something new going on? Is it that it is overpriced? I mean, any number of issues.

So the question is, does the specificity on volume as compared to some suggestion there might be some combined effect here give us more information that would be useful in looking at the adequacy of the payments by type of service? But what I hear you saying is they track so closely disaggregating them may or may not have any benefit to our understanding.

DR. REISCHAUER: I think there's enough here to cause an eyebrow or two to be raised. That office

visits for establishment patients weighted by the complexity should rise at 4.3 percent in one year you think, drawn out over a decade what would this imply about health care costs in America? Consultations 6 percent in a year. Some of these numbers seem very, very high in areas that you don't expect there to be huge procedure-type changes like imaging where imaging is being used for things that it wasn't being used for before.

DR. ROWE: Are these data corrected for any changes in the patient population?

DR. HAYES: No, they're not.

DR. ROWE: Because we have this experience, and I know in one year it's not dramatic, but that the elderly are getting older and that the average age of Medicare beneficiaries is increasing. There's a very steep relationship between age and utilization.

DR. REISCHAUER: It's not increasing, I don't think. As the baby boomers enter, the average age of Medicare will fall.

MS. DePARLE: There are more old-old.

DR. NEWHOUSE: That's also true.

DR. ROWE: But the baby boomers aren't entering yet. I'm the world's oldest baby boomer and I'm 59. So as the baby boomers enter Medicare that will happen, but we're talking about what happened last year not what's going to happen in 2010. So I think that with increases in longevity -- I'm just wondering that's going to discount this number a little bit into if you correct, that's all.

DR. NEWHOUSE: Medicare costs don't go up that sharply because the medical care system isn't that aggressive with the oldest old. They fall out at the end.

DR. ROWE: I'm aware of those data. I was thinking about number of visits. Those data are related to hospitalizations and length of stay and stuff like that, and people don't get hospitalize when they're older. Not number of doctor visits.

MR. MULLER: What was the payment update in '01, '02? Could this be one of those expenditure offset type -- what did we call that, those days?

MS. BOCCUTI: You mean what was the actual or what we recommended?

MR. MULLER: What was the actual payment increase in '01, '02 for physician? Was that a cut year?

DR. HAYES: Yes, minus 5.4 percent.

MR. MULLER: Insofar as there's been speculation on expenditure offsets and so forth this might --

DR. NELSON: But notice that the highest category of those kinds of services was emergency room visits which are largely patient initiated. They're the ones that decide whether to go into --

MR. MULLER: I'm not suggested, Alan, it's across the board because obviously the imaging ones are technology driven, and we discussed this last year, the price of the imaging devices has gone down considerably therefore making the diffusion of them much more possible. These used to be $2 million tickets and now you can get them for $500,000, et cetera, and so forth. So I think there's different explanations for different parts of this but I agree with the point that either Bob or -- these are pretty big numbers if you start compounding them for ten years.

DR. MILLER: I'll just also remind you there's been a couple of other discussions of volume growth here. We went through, Kevin went through things when we were disaggregating volume growth over a series of years looking at imaging and different services and I think you'll remember that. You were seeing differential volume growth in different service settings, and some of it fairly aggressive. Then we commented on the AHRQ report on volume where they were disaggregating it and trying to track to things like change in demographics and those kinds of things and they were finding that volume was growing in excess of what those factors could explain, if I remember correctly.

MR. MULLER: But one of the themes, Glenn, that we've had cutting through our discussions for a couple years now is looking at utilization and there's all kinds of reasons why utilization is going up, will go up, will probably accelerate. Not just the decline of managed care, the technology, the aging. So obviously a lot of what we think about here are payment rates in our discussions, discourses, recommendations.

But I've been arguing for a couple of years now it's utilization that's going to drive this even more than the payment rates. And there's absolutely no break and as I would say and I'm sure a lot of you agree, a lot of accelerators on utilization inside our system and there's nothing in sight to put a brake on that.

DR. HAYES: Just if I may, one more point on that. We will have an opportunity to look more closely at this issue of volume growth. The Medicare legislation has a mandated study in it for us to look at the volume of physician services addressing a number of the issues that you brought up here today. That's due in December of this year.

MR. HACKBARTH: Any other questions or comments?

Okay, I think we're ready to move on to the draft recommendation then. All opposed to the draft recommendation which is on the screen? All in favor? Abstentions?

Okay, thank you.

Next we have home health.

MS. CHENG: In this presentation I'll review

our evidence and discuss some new information in response to questions that you raised at our December meeting. I hope that I've addressed your concerns in the draft chapter and the materials that we'll discuss today. I'll start my presentation with a new recommendation for your consideration in addition to the recommendation that we discussed at the past meeting.

The idea of two recommendations is a pretty important one here because I think we will find that we have two issues on the table. One, is there enough money in the system to adequately cover the cost of providing care to Medicare beneficiaries? And two, are the structures of the payment system making some eligible beneficiaries less financially attractive than others and possibly creating access problems?

I think we could find that there is enough money in the system but at the same time certain types of beneficiaries are less financially attractive than others.

I'll start with the context for our recommendations. Current law is market basket minus 0.8 percent to be implemented on January 1st, 2005.

Spending in 2003 for this benefit was $10 billion. The Congressional Budget Office projects that home health spending will grow 17.7 percent in 2004 and continue to grow at an average annual rate of 14 percent from 2005 to 2009 driven by continued growth in volume.

Another part of the context for making recommendations in this benefit is that the definition of this benefit is not clear. The benefit is not clear because it's not bound neatly by the coverage described in statute. By statute, the purpose of the Medicare home health benefit must be the same as the general purpose of all services covered by the Medicare program, the diagnosis or medically necessary treatment of illness or injury over a spell of illness.

However, precisely how the concepts of medical necessity and spell of illness pertain to home health care is less clear for this service than it is for others. In home health there are no definitive clinical practice standards to determine what treatments are necessary and for what kinds of patients they are appropriate. And the amount of service covered by the home health benefit for those who are eligible is fairly

broad. It includes the skilled services necessary to treat patients, nursing and therapy, as well as ancillary, non-skilled or non-medical services that are necessary in conjunction with those skilled services to maintain the patient's health or facilitate their treatment.

However, unlike other services where the range of services is fairly broad, there is no explicit spell of illness for which Medicare coverage applies. Instead, coverage relies on eligible criteria, whether a beneficiary is homebound, has a medical necessity for care, and needs care on an intermittent or part-time basis. However, here too the definitions of homebound and medical necessity are not explicit. Coverage decisions are made on a case-by-case basis by intermediaries who do not have clinical guidelines nor precise definitions of the criteria to work from. So as a part of the context for our discussion we're going to have a certain amount of ambiguity.

At our past meeting my presentation and materials were focused on aggregate measures, especially cost and beneficiary access. However, aggregate

payments may be greater than aggregate costs and many beneficiaries may have access while the structures of the prospective payment system inappropriately encourage providers to serve some types of beneficiaries and discourage the services of others. The decline in use from 1996 to 2007 certainly suggests that we should be on the lookout for structural issues. The changes that were made in the mid '90s were intended to reduce spending and use of the benefit but not to exclude any group of eligible beneficiaries.

We also have evidence that there was a disproportionate decline in use among some types of beneficiaries. If some types of eligible beneficiaries have been excluded from the benefit because of the structure of the payment system then the system needs structural change and we should be on a track to look at whether there should be structural change.

We already know that three factors interacted to precipitate the decline in use. The Secretary initiated Operation Restore Trust in an effort to reduce fraud and abuse. It prompted the involuntary closure of hundreds of agencies that were not in compliance with

the program's integrity standards and established civil liabilities for physicians who knowingly falsely certified the eligibility of a beneficiary. Through the investigations in Operation Restore Trust the Secretary found that fraud and abuse was not uncommon during the peak years of use.

Changing eligibility also had an impact on use. In 1997, the BBA clarified the acceptable frequency of visits and removed the drawing of blood as a qualifying service. Agencies reported that changing those eligibility criteria to exclude the drawing of blood decreased the number of users significantly in at least six high-use states. By defining the term part-time or intermittent the BBA narrowed its coverage of very frequent or nearly full-time care.

Changes in the payment structure also contributed to the decline. When Congress changed the law in BBA '97 and HCFA and CMS implemented those changes the new structures changes favored short-term recovery care over long-term maintenance care. The payment system gives a heavier weight and hence higher pay to providing therapy as compared to skilled nursing

or aide service and is neutral towards the presence of a caregiver in the home.

Though decreasing use through reducing fraud and abuse or decline in use that followed a change in eligibility would not be cause for alarm, we should not be sanguine about the 1996 to 2000 decline because structural change may have made some beneficiaries less financially attractive which could have impeded their access to care. MedPAC conducted two studies to determine whether the general decline in use was accompanied by the exclusion of certain types of beneficiaries. In both of our studies we focused on the characteristics of beneficiaries in 1996 as the peak year and then compared them to beneficiaries who used home health after the large decline in use.

In our first study we could not identify a particular type of beneficiary that had been excluded from the benefit. Rather, almost every type of beneficiary used home health care in 1996 and to some extent still used home care in 2001. So instead we looked at the likelihood of beneficiaries using home health care and then compared it to the likelihood of

similar beneficiaries using the benefit in 2001. What we found was that those with a clear need for the benefit, which is to say that many or most beneficiaries of that type used home health care in '96, those types of beneficiaries had the smallest decline. Those with a less clear need, which is to say some of the type of beneficiary used home health but most did not even during the peak years, that group had the greatest decline.

We found mixed results in our second study. Two types of patients who may be less financially attractive were not disproportionately excluded from the home health benefit during the period of decline in use. Between 1996 and 2000 the average age and the level of functional disability of patients increased. These trends suggest that the older-old and the functionally limited were still using the benefit after the period of decline.

On the other hand, we found that the proportion of users who did not have a caregiver fell over this period. That latter finding is consistent with a decline in the number of home health aide visits

provided by home health agencies. Because of the heavier weight given to therapy and the neutrality of the payment system toward the presence of a caregiver the types of beneficiaries who experienced disproportionate declines may be those who are less financially attractive.

So is structural change needed? I think that based on the evidence we have we have some mixed signals. Home health agencies may be serving fewer beneficiaries because of changing eligibility or program integrity oversight. If so, then neither changing the base payment nor the structure of the system would increase use. Alternatively, they may be avoiding some types of patients because they anticipate a substantial loss on those types of patients. Making a structural change by improving the outlier policy may improve access for this type of beneficiary, and we are studying the outlier policy.

Another explanation may be that they are avoiding some types of patients because those types are simply less profitable than other types. Now every prospective payment system is built on the assumption

that some patients will be more profitable than others, otherwise we would have a cost-based system. But if subgroups of patients cannot get care or the providers who do care for them are disadvantaged by caring for them then a structural change would be necessary.

So to follow this track, MedPAC will examine the structure of the payment system. We're going to look at the relationship between case mix and the financial performance of agencies. We're going to analyze two large demonstrations which broaden the homebound definition. We're going to extend our analysis of changes in the characteristics of home health users, especially their Medicaid status, their level of cognitive impairment, and their behavioral health issues. We're also going to study the outlier policy.

These additional steps also are necessary. The Office of the Inspector General will continue to monitor access to care for beneficiaries following hospitalization. CMS should continue the CAHPS survey as an important part of monitoring all beneficiaries access to care. And the Secretary should continue

efforts to identify similar patients across post-acute settings and compare their use of care.

So on this track to pursue our concerns about beneficiaries who may be less financially attractive we come to draft recommendation one. The Secretary and MedPAC must continue to monitor access to care, the impact of the payment system on patient selection, and the use of services across post-acute care settings. Because of the exploratory stage of this recommendation I cannot quantify it's spending implication and at this point neither can I quantify the implications for beneficiaries and providers.

DR. NEWHOUSE: Sharon, since we're just monitoring why are there any spending implications or beneficiary implications? Those implications would arise if we did something based on the monitoring.

MS. CHENG: That's right. We could say none.

DR. WAKEFIELD: I don't recall that we've included references to MedPAC in other recommendations. Is there a reason why we feel compelled to recommend to ourselves here, rather than just making a recommendation to the Secretary? We assume that we're going to do this

anyway, but why --

MR. HACKBARTH: I think you're right, Mary, so let's drop the reference to MedPAC. So we'll express our intent in the text by what we do. Good point.

MS. CHENG: On our second track then, we will consider evidence regarding aggregate payments and costs. Our first factor is beneficiaries' access to care. We found that most communities have a Medicare-certified home health agency. 99 percent of all Medicare beneficiaries live in an area that was served by least one home health agency in 2003. Most beneficiaries can obtain care when they seek it. Nearly 90 percent of beneficiaries surveyed about their experiences in 2000 reported they had little or no problem with accessing home health services. That percentage remained essentially the same in 2001 and 2002. The comprehensive geographic coverage and low rate of access problems suggests that access, in the aggregate, for most beneficiaries is good.

The next pieces of evidence that relate to whether aggregate payments are right are changes in volume. One measure of volume is the number of

beneficiaries who use home health. Between 1996 and 2000 you can see the decline in the number of users. As time passed without major changes to the payment system the total number of beneficiaries using the benefit grew for the first time in several years between 2001 and 2002. Both the Congressional Budget Office and the Office of the Actuary at CMS project that use will continue grow.

MR. HACKBARTH: Sharon, could you say just a little bit more about that? On what basis are OAC and CBO projecting that? Do you know what their thinking is?

MS. CHENG: They have a similar set of assumptions. They're not entirely aligned. In CMS's most recent report they noted that changes made to the homebound definition in one of the most recent pieces of legislation could lead to an increasing eligibility. They both note that the characteristics of the Medicare population would lead to higher use if the rate remained the same. They also see that there will be a growth in the number of episodes per beneficiary.

MR. HACKBARTH: I remember seeing in the early

part of your presentation that CBO's projecting of an average annual increase in expenditures of 14 percent allowing a little bit for growth in the beneficiary population and a little bit for updates is in there. That's implying a fairly substantial increase in volume.

MS. CHENG: That's right. When we look at some other measures of volume we see volume actually starting to stabilize in 2001. Between 2001 and the beginning of 2003, the number of episodes per beneficiary remain the same, visits per episode decline only 1 percent and the average length of stay increased slightly. Thus, I think that the last couple of years suggest that the historically rapid changes are slowing. We have just entered this phase of moderate change and we should not try to extrapolate too far from what we've seen but it does seem to suggest that the phase of agencies rapidly reducing the services they provide within an episode is ending to be replaced by smaller changes.

The reduction in the volume of services was anticipated by CMS and GAO as the PPS was being developed. Both groups stressed the need to monitor the

quality of care to determine whether the changes were improvements in efficiency or stinting on necessary care. MedPAC worked this summer to look at quality changes. The work we did with our contractor, Outcome Concept Systems, is parallel to the work by the Agency for Healthcare Research and Quality in their national health care quality report and to CMS's Home Care Compare.

To get a complete picture of quality at the agencies and to be consistent with CMS and AHRQ we included patients with Medicare primary payer as well as those with Medicaid. Scoring outcomes for home health is very new so we don't have much of a context by which to judge what the right score is. However these scores provide a baseline and allow comparisons over time. The median score for this quality index was .0.7 in both periods. The average outcome score rose slightly and the variation narrowed. Because we used all records for all patients to derive these scores we can conclude that the differences between those years were real and were not caused by sampling.

We could conclude that quality has remained

stable at a good level. For example, in 2002 for every clinical and functional indicator that we looked at such as shortage of breath or ability to move around, at least twice as many patients improved as declined, and sometimes three or four times as many. There was also improvement between the two years as the rate of emergent care and unplanned hospitalizations declined. However, on some measures there is room to improve. The number of patients who did improve as a percentage of those who could improve was less than 30 percent for five out of 20 measures in 2002.

The stability of this score has some implications for assessment of payment adequacy. There were concerns that as agencies reduce the number of visits they would cut out visits that were necessary to achieve quality outcomes. Instead we observed that the decline in the number of visits is concurrent with stable adjustable quality.

MR. DeBUSK: Overall, the prospective payment system for home health is this real successful? Is that the general opinion that the OASIS assessment system and all this?

MS. CHENG: I think there are a lot of people who are still looking at this. We're only three years into the system and as far as data we're maybe one or two years into the system. So I guess I'd rather call most people's opinions tentative than conclusive.

The next piece of evidence that we consider are costs over the coming year. The market basket for home health for 2005 is 3.3, and that market basket reflects the increases prices of transportation, nursing wages, and other inputs that affect the cost of providing an episode of care. Even though input prices have been rising over the past several years, the cost of producing an episode has fallen recently and there is no evidence that appears to suggest that costs increase.

We cannot disentangle the separate impacts of changing product of productivity, but we have estimates of their combined effect. Cost per episode fell 16 percent from 1999 to 2001 as the number of visits per episode was reduced by half. The rate of decline in the number of visits per episode continue at a much slower pace from to 2001 to 2002 but our 2002 sample of cost

reports indicates that costs per episode continue to decline at 1 percent between those two years. Over the coming year we expect the slow changes to continue and do not expect costs to rise.

MR. HACKBARTH: Let me just make sure I understand the last part. Last year when we were making this decision we just had a partial year, 2001, partial sample of the 2001 cost reports which was a problem that we struggled with. So now we have the full year of 2001 and part of 2002?

MS. CHENG: Right.

MR. HACKBARTH: And when you look at the actual costs reported there there was a decline in costs per case from '01 to '02?

MS. CHENG: That's right. It's only one year.

DR. WOLTER: I had a question on this point too, because also in the body of the paper you talk about increased productivity. But I'm wondering if it's possible that the patient population or the product change is more the driver of the cost improvements as opposed to productivity in the traditional sense.

MS. CHENG: Absolutely. That's why in this

setting I haven't tried to pull apart product change and estimate that and then productivity and try to estimate that. What I'd rather do is just go with what I can observe and say some it's been product change and some of it's been productivity.

DR. NELSON: Kind of on this point because it has to do with product change. Sharon, first would it be useful to have some comparison between the kinds of services that are provided by an agency to their commercial business as compared to their Medicare business? For example, are some entities excluding certain Medicare patients from their services? It might be that they will provide IV antibiotic therapy at home for their commercial business but not for their Medicare business because of differences in payment.

And are agencies accepting commercial business with different payment policies than the PPS? Is there still a lot of their business, their commercial business, based on fee-for-service?

I think it would be really useful for us to use the private sector as some comparison to reassure ourselves that Medicare payment policies are

appropriate. Is commercial business a big part of most agencies? Are there some agencies that don't accept any Medicare business because they have ample commercial business? And is the menu of services different depending on the payer?

MS. CHENG: We can give that a shot. One of the things that would make that difficult would be trying to find a group of patients on the private side that were comparable to the Medicare patients without -- we're not going to have a nice case mix adjuster over for our private group. We do know that home health -- Medicare is built on a medical model of home health care and a lot of the private services are home care. So while there's certainly a medical component, there are more home care components, light housekeeping, meal prep, that are going to be mixed in. So you're going to have a little bit of apples and oranges in trying to compare those two groups, but we can see what's out there to measure those two groups.

DR. NEWHOUSE: Would we have any information about agencies that don't take Medicare patients?

MS. CHENG: I don't know where we'd get it

right off the top of my head.

MS. DePARLE: Otherwise all you have is who's a Medicare-certified home health agency, who participates in the Medicare program. Those numbers are hard enough, as you point out in the chapter, about how many are there, and how much changes there have been since the BBA. That's very hard to pin down. But I think the trade associations would have some sense of it maybe.

MS. CHENG: The next factor in our framework is a comparison of Medicare's payments and costs. In modeling 2004 payments and costs we incorporate policy changes that would into effect between the year of our most recent data, 2001, and our target year, 2004, as well as those scheduled to be in effect for 2005.

For the home health sector the 2004 estimate includes all aspects of current law including a decrease in the base rate that's scheduled for April 2004 of 0.8 percent. Our model generates a current aggregate margin of 16.8 in 2004, a slight improvement since the first full year of PPS. This margin suggests that the payments are greater than the costs of caring for

Medicare beneficiaries. The distribution of margins from 2001, our base year, indicated that 80 percent of agencies had positive margins and agencies with positive margins provided 82 percent of all episodes to beneficiaries.

MS. BURKE: Could I ask a question on that? I went back to the chapter because I didn't remember seeing it so I don't think it's there. You can go to the next slide where you have reflected the variation between hospital-based and freestanding on a variety of issues. What we don't see are the margin differences. We see total margins for total delivery but not for freestanding as compared to hospital-based. Do we have that data?

MS. CHENG: We do. Our margins are based on a complete set of freestanding agencies' cost reports. When we looked at cost reports from hospital-based home health agencies we estimated a margin around 3 percent.

MS. BURKE: I think that needs to be reflected in the text unless there's a compelling reason not to.

MR. HACKBARTH: Here again we have our usual issues about what does that mean and how the costs are

allocated between --

MS. BURKE: Right, but if we're going to array all these other data points, case mix, visits, rural as a percent, then I think we ought -- because the issue will come up and has come up that in fact the margins are different. I don't know what it tells us from a policy perspective but it is a reality and it is a data point, if we're going to reflect the others.

DR. NEWHOUSE: I think the implication of this is that in fact it may be an accounting difference. I took the thrust of the argument in the chapter to be on other measures than the accounting measures they don't seem to be that different or we don't see why they can't be as costly. That was what I thought the implication was, or the argument was.

MS. BURKE: Certainly the case mix appears to be similar although freestanding seemed to be higher. Episodes, rural they're predominantly -- the hospital-based are predominantly rural. There's a variance there and there's certainly a variance in terms of --

DR. NEWHOUSE: But let me put it another way, you couldn't use these measures to account for a big

difference in margins.

MS. BURKE: I agree. My only point is it is a factor. I don't know what it really means nor that we should do anything about it. But to state that the absolute of the margins are 16 percent when in fact -- and you do correctly, and I appreciate this, state that that is based on the freestanding -- I think the obvious question that arises is, all right, what is it for the other 30 percent?

MR. HACKBARTH: I agree with that, so let's put it in and then, along the lines of what Joe was just saying, it's not evident from data like these --

MS. BURKE: Why there's a difference.

DR. MILLER: Can I just make one comment on this? I apologize. What drove this whole thrust of the analysis were a set of questions we got here in December, and this comparison and all of that. I think our feeling about this, and I know there is frustration with this issue and we feel it as well. Our feeling about this is that using the hospital-based margins from the cost reports we get from the hospital are very misleading.

MS. BURKE: I understand.

DR. MILLER: So we did this mostly to make the point of they could very well be misleading. Some of my reservations in listening to this is, if we're going to get into the regular process of saying, this is what the hospital-based home health margin is, I think that's going to be -- I don't know if that's something we want to do. The whole reason we do the all-of-Medicare margin is because we don't believe the pieces of it.

MS. BURKE: I'm sensitive to that and I appreciate that there are huge issues with these numbers, not the least of which is the hospital cost report and how one allocates costs and all the other issues that are part of the whole debate about how one considers margins. But my concern, Mark, is that in this instance we affirmatively state a margin for freestanding. We have one-third of the agencies are not freestanding. It begs the question, having stated affirmatively it is a margin for the freestanding, what's the margin for the not? I know it brings all those other issues and I'm happy to have it footnoted, caveated, that the number is dog exhaust.

But the point is, it may not tell us anything about how real the number is, or that we ought to do anything about it, but I think to not state it leaves a question.

MR. HACKBARTH: I agree with Sheila. I think in terms of having our reports, coherent, understandable, I think this adds to them. It's a question. It's an obvious question. It's been asked by commissioners. It's been asked by other people. Rather than pretending it doesn't exist, we're better off addressing it explicitly. Saying, here's the number --

MS. BURKE: And say the number is not a number we're comfortable as really -- we can fully identify as being accurate based on the issues that arise because of cost reports and hospital-based activities. I personally am not prepared to -- I'm not asking you to do it so that I can then next time say, see, we ought to have done something for the hospital-based. I know you're fearful of that for good reason. Having stated a number, the number is a discrepancy, people say, okay, what's the story here? But I think not to state it leaves the question out there.

DR. NEWHOUSE: I have an alternative proposal, that we state it but we state a range that goes up to something around -- then the freestanding, with the argument that based on these data if one had some numbers that didn't include the arbitrary allocations a truer measure might be this. The case mix is actually greater in the freestanding, which would suggest that, if anything, the hospital margins might be greater than the freestandings.

MS. BURKE: Right; one would think.

DR. REISCHAUER: But doesn't that depend on what the payment is versus the case mix? The profit margin maybe is larger for simpler things than for more complex things.

DR. NEWHOUSE: But I'm assuming the case mix is calibrated to approximate the cost or at least on average is unbiased in these two entities. It may not be but that's why I wanted a range. There's a lot of uncertainty here, statistical. Just to put a point estimate of whatever it is, minus three or plus three for the hospital-based seems to me to be -- to really mislead. It seems to me a way to get around that is put

in a range.

MS. BURKE: So, Joe, let me make sure I understand your proposal. Are you proposing that for hospital-based we give a range of, whatever the range is, zero to three or whatever is, and for the freestandings, similarly, we state a range that's X to 16?

DR. NEWHOUSE: Not the freestanding. Here's the argument. The argument is that we have a number we more rather than less believe for the freestanding. We have a number for the hospital-based that we don't believe, so if we just put in a number we would basically say, here's the number but here's why we don't believe you should attach any reality to this number, which seems like a strange way to go. Instead of that, if we're going to put in a number then say, but we think a better number than this number is something that approximates the freestanding number.

MS. BURKE: On what basis do we say that?

DR. NEWHOUSE: That's what I read as the thrust of the argument or the implication of these numbers.

MR. SMITH: No, the implication of these numbers is the one that Sheila is suggesting, that we don't trust the hospital number but given the cost reports it is the number we have. We are comfortable with the freestanding number.

DR. NEWHOUSE: The difference is both of these agencies are providing a service out in the home. The chapter makes that point so there's no particular reason why costs should differ between hospital-based and freestanding agencies other than these kind of factors.

DR. REISCHAUER: But let's imagine that 0.3 or three actually was the right number for hospitals and we have this freestanding entity that can do it a lot more efficiently. We would not argue that we should pay inefficient providers unless there's some particular reason why this needed to be performed in a hospital, which it isn't being performed in anyway.

DR. NEWHOUSE: That's also true. But the problem -- we encountered the same thing on the SNF side. So if we're going to maintain --

DR. REISCHAUER: But sometimes they're imbedded --

DR. NEWHOUSE: But there the site of service is the hospital in most cases. But still the general burden of the argument is that the cost number -- when you're allocating joint costs, costs don't -- what costs are we after? Are we after incremental costs of home health agency to the hospital? That's not the number we're reporting.

DR. REISCHAUER: But I can make a case for why hospital-based home health would be more expensive because the labor agreement for nurses was part of a larger structure, the administrative structure was more complex and it's just a less efficient way of providing something. It's interesting but it should drive our payment policy.

DR. WOLTER: I would just say, it's kind of the eye of the beholder. You could also look at this data and say that since hospital-based have many more rural agencies, they're lower volume and therefore the overhead is higher per beneficiary leading to lower margins. You could choose to make many different arguments, but I think Sheila makes a good point. We put the number in. We don't really know what the real

answers are today. But over time we probably due need to address what some of the differences are.

MR. HACKBARTH: We do disaggregate the data elsewhere, urban versus rural, and there's not a big difference as I recall on an urban-rural basis. So that wouldn't explain --

MS. BURKE: There is on volume.

MR. HACKBARTH: Volume is the more important predictor. But even then the lowest volume are still not as low as 3 percent.

MS. CHENG: No, they're 12.

MS. BURKE: But you could imagine transportation -- I mean, there are a lot of issues that presumably one experiences in a heavily loaded rural -- I don't know. I mean I don't know why they're different and I don't pretend to believe that they're necessarily accurate.

MR. HACKBARTH: So that's where I'd like to leave this. I think that we ought to include the data. We ought to explain why we're not sure that it's an accurate number. In addition to that, I would like to see us to make Bob's point that even if it were an

accurate number it shouldn't necessarily drive payment decisions. So those are the basic points to include.

MS. CHENG: Within this context then using the evidence that we've reviewed I think we come to this conclusion on our second track. Congress should eliminate the update to payment rates for home health services for 2005. This recommendation would reduce spending by $200 million to $600 million over one year and by $1 billion to $5 billion over five years compared to current law. We believe that the adequacy of payments in the current year and over the coming year in the aggregate suggest that there will be no major implications for beneficiaries or providers.

With that I'd like to close my presentation and turn it over for discussion.

MR. HACKBARTH: Any other questions or comments?

I have a question and I guess it relates most to the earlier recommendation about monitoring and expressing concern about particular types of patients. I need some help remembering how the case mix system works. As I recall from the text, you say that patients

with less well-defined needs may be less attractive financially because the system isn't adjusting for factors like their functional status and cognitive state. Did I remember that correctly?

MS. CHENG: Actually, their functional status is a pretty big part of the case mix adjuster, but their cognitive status, behavioral health issues are not a big part of the case mix. So if those make the patient less financially attractive they're not a big part of the payment.

MR. HACKBARTH: What was the thinking behind the decision to exclude factors like that from the case makes adjustment? As a layman it seems like they may well affect the cost of caring for these patients.

MS. CHENG: I think that part of the issue when they were designing the case mix is that they were trying to build a case mix adjuster that was intuitive for the clinical practitioners in the field, and especially for some of the cognitive problems and for some of the behavioral problems there was a feeling that some of the practitioners weren't as confident about their ability to adequately assess a patient in the

home. A PT may be much more comfortable with his or her ability to determine whether the patient has the ability to move around rather than a cognitive impairment. So part of that was, what was the consensus among practitioners in the field that they could really measure, that they could understand the care path for, and that would be an intuitive case mixer. So there were issues with some of those measures.

MS. RAPHAEL: Just to add to that, I think the other part of it was thinking about tasks that you could somehow concretize and capture and a rehab interaction is easier to capture.

Now I think I made this point and I think it's important and people should understand this, you could have a lower case mix in the system today and consume more resources. It's very, very possible and quite common, because if you have cognitive impairments, if you don't have a caregiver, then you have to put in more service units although the case mix doesn't capture that and you don't get paid for those additional units of service. That's why it is also possible that if you're in a market where you have higher demand than supply you

could be choosing the cases where the case mix index better captures and rewards you for the provision of service.

So I think that is important to understand in all of this and it's why I support the need and am very glad to see it's reflected here today, the need to monitor access, the need to really step back, which is entirely appropriate. When we put in this prospective payment system we well understood that we were changing some of the incentives here and that we had to come back and modified it as we saw it implemented. So I think those areas really need to be focused on.

The other point that I wanted to make is that, I guess this is building on something that Nick said, I don't know where we are on quality. I would not move to say that quality is stable, because I don't think we're caring for the same patient group today that we cared for in 1999. So, yes, maybe rehospitalization, unplanned rehospitalization and emergent care has gone down, but that may well be because the number of congestive heart failure and COPD patients have dropped very dramatically, so therefore you're not getting the

same rehospitalization rates.

So I'm just not as comfortable saying that quality is stable. I don't know that it hasn't improved or that it's stabilized or it's decreased. I just don't think we know enough at this point because it's very much tied to the change in product and the change in the patients that we're currently seeing.

DR. ROWE: Carol, it's very interesting about the imperfections in the financing with respect to the resource needs per patient, but let me see if I can follow the logic because I'm not sure I get to the same place you do.

If the conditions that are required for your scenario are that demand exceeds supply, let's say there are 120 Medicare beneficiaries and resources to take care of 100 of them, and what you're saying is that if the payments are such that people are going to differentially avoid patients with dementia or something because they're going to get paid less then what we're going to have is 20 patients with dementia who didn't get into home health and that's going to be a subset that's easily defined.

But if that's not the case and if payment system were perfect across all diagnoses you're still going to have 20 patients who are Medicare beneficiaries who aren't going to get treated because the defining condition is demand exceeds, supply. You can only take care of 100. But instead of all having Alzheimer's they're going to have a variety of things. How are we better off?

So it seems to me that, yes, it's true that certain subgroups would be differentially disadvantaged but for any given patient it's that given patient. And the answer is that if demand exceeds supply then we should change payments or something in order to try to get a stimulus to get more supply.

DR. REISCHAUER: But there's one for condition, and that is for the dementia patients you have to be losing money if you take them on, not just making less money than you would if you took on somebody else. Then there's another question which you'd have to ask under your scenario is, what keeps this industry from expanding, if there is excess demand, when there's a 16.8 percent margin here on average?

DR. NEWHOUSE: On Medicare.

MS. RAPHAEL: That's a good question, why isn't there more entrants into the industry with this kind of margin? I think that is a good question. I would answer your question that I would increase my supply because it then would be worthwhile for me to perhaps pay more, et cetera.

DR. NELSON: Help me, Sharon, and perhaps Carol, so I don't climb up a wrong tree here. Is there any substantial risk of having payment policy create a two-tier system in which Medicare patients get a substantially inferior level of care in their tier? Or is Medicare such a dominant payer within the home care industry that that's not a concern? My comments were directed toward whether Medicare is being disadvantaged in competition with private business. I really don't know. I don't know whether the risk of a two-tier system is worrisome or not.

MR. HACKBARTH: On these facts, I don't think you would be worried about that. It's the Medicaid patient maybe that you would be worried about. But Medicare is paying well.

DR. NELSON: Medicare is just fine?

MS. CHENG: In the financial analysts' papers they routinely note that Medicare is the highest margin payer in the industry.

DR. NELSON: Good. Thank you.

MS. RAPHAEL: The total margins I believe, Sharon, are about 2.3 percent overall for the industry when you put the payers together. The most difficult subset are the dually eligibles or the Medicaid patients who tend to fit more into the complex case or the need for supportive care categories.

DR. NEWHOUSE: I want to go back to the issue on margins by line of business at the hospital. Let me make an argument that we basically don't want to present those numbers in any of the products. So let's first say for the sake of argument that we want to keep the hospital in business as a multi-product firm. So this is not the hospital that's failing. Then the issue is either the total margin or what we've called the most-of-Medicare margin. It's not the individual lines of business. We can and weekend and should present those numbers, and do.

Then when we now get to the product line we want to say, do we want to keep the hospital in business as a producer of whatever, home health, SNF, whatever? Then if anything, the cost numbers that would be relevant to that are the reverse of what we have in reality. That is to say, if you start with the assumption, which I think is reasonable, that the inpatient service is the service that's there first and these other services either are there or not there given that the inpatient service is there. Then the issue really is how much does it cost the hospital to add this extra service at some scale of business?

Under those assumptions you would allocate the joint cost to the inpatient side, and you would say it's just the incremental cost of adding home health that we should allocate to home health, and SNF, and so on. Now in fact what we've got is exactly the opposite. The hospital could push in as much of the joint cost as they can out of the inpatient side. So I think, as I say, the individual numbers are -- when we say we would like the true number, there really isn't a true number unless you go to this incremental definition which is far from

what we have or could, I think conceivably get.

Whereas, the most-of-Medicare margin I think does have a meaning and the total margin has a meaning.

DR. ROWE: Are you suggesting that, therefore, for the different, as you call them, the different product lines, inpatient, outpatient, SNF, et cetera, that we not show those that all?

DR. NEWHOUSE: Yes. I just don't think that -- because it's inherently arbitrary where you put these joint costs, unless you want to say, you should basically put them over on inpatient, which is not anything like the numbers we have.

DR. WOLTER: I'll try to be brief because we're really not deciding this issue today I hope. But I would really disagree with that argument, Joe.

Number one, I think each of the of the key to the PPS systems is based on a system of averaging, but they weren't designed to be blended together. Even within one system we currently have DRGs that are quite profitable and some that aren't, and there are decisions being made in terms of strategy and product line development based on that knowledge in the industry.

Similarly, we have other recommendations that suggest that we want different sites of care for the same thing to, roughly speaking, be given the same payment. So if we're not even tracking what happens in hospital outpatient, how do we have the discussions about ASC? I think there are so many problems with not charting a course in terms of our framework and philosophy that addresses this issue, wherever we go, that we could get ourselves into. But I think there would be many, many reasons to continue to try to look at the individual PPS system because that's how they were set up.

MR. HACKBARTH: In addition to that, one of the reasons why I don't think we can just whistle by this one is that the issue is out there, even if we don't choose to address it. For example, as I understand it, one of the differences between the industry's margin calculation and ours is that theirs includes the hospital-based agencies and they pull down the average with that.

I think we need to talk about this issue in this chapter this year and if we, for all the reasons

that have been discussed, are skeptical about those numbers, don't think that even if they were right they would be the appropriate basis for payment policy, we need to lay that out. So as opposed to just saying, it shouldn't be there and we're not going to talk about it, we've got to talk about it.

MS. RAPHAEL: I think that's really important because the industry has done its own analysis and its numbers are quite different from the numbers that MedPAC has come up with. I do think we need to be able to explain what those differences are.

MR. HACKBARTH: We need to move ahead at this point so do you want to go to the other recommendation? We'll make the editorial change suggested by Mary. All opposed to this recommendation raise your hand. All in favor? Abstentions?

Then on the update recommendation, all opposed? All in favor? Abstentions?

Okay, thank you, Sharon.

DR. SEAGRAVE: Good afternoon. I will now briefly review the evidence regarding SNF payment adequacy for fiscal year 2004 and present the draft

update recommendation for fiscal year 2005. Since you've seen most of this at previous meetings I will be brief.

The evidence we have suggests that most Medicare beneficiaries have access to SNF services but that certain types of patients with special needs, such as those who have diabetes, need ventilator support, are morbidly obese, or who 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. However, this finding may point to problems with the distribution of payments in the SNF payment system, and we'll return to this point later when we discuss the second draft recommendation.

In terms of supply, the overall supply of Medicare-certified SNF facilities and SNF beds appears to have been pretty stable since 1998 with the total number of Medicare-certified SNF facilities declining by less than 1 percent between 1998 and 2003. As you can see from this graph, the number of Medicare-certified freestanding SNFs has grown pretty steadily since 1992. This is the yellow line. The number of hospital-based

SNFs, however, peaked in 1998 and has declined each year since.

From 2002 to 2003, the most recent data we have, the number of Medicare-certified freestanding SNFs grew by about 2 percent and the number of hospital-based SNFs declined by 9 percent. Note that Medicaid-only nursing homes, that is nursing homes that do not serve Medicare SNF patients, are not included in this graph because they are not relevant to our discussion. Their numbers have been declining in recent years.

In 2001, the most recent year for which we have data, the volume of SNF services grew with discharges increasing by 6 percent, the number of covered days increasing by 8 percent, and the average length of stay increasing by about 2 percent.

Evidence regarding quality of care is mixed. I want to pause here for a moment and discuss this a little bit since it came up at the December meeting. Most of the evidence we have regarding quality of care in SNFs is from the year 2000 and before and much of it comes from studies of overall nursing home quality rather than quality of care in SNFs specifically.

Recall that about 90 percent of all SNFs are located within nursing homes. We generally assumed that nursing home and SNF quality are related.

Overall then, studies of patient care in nursing homes have tended for many years to find room for improvement in the quality of care delivered to nursing home residents. In addition, some studies have suggested that nurse staffing levels in nursing homes declined and the number of reported deficiencies in nursing homes increased between 1998 and 2000, the years immediately following the SNF prospective payment system. Studies of patient assessment data, this is data on functional statue of beneficiaries between 1998 and 2001, including MedPAC's own analysis of adjusted rehospitalization rates, found mixed results for quality. A GAO report provides the most current evidence we have showing that the overall number of serious deficiencies in nursing homes declined somewhat between 2000 and 2002.

Given this mixed picture what can we do to improve the quality of care in SNFs and in nursing homes? The first thing we can do is collect more

information with which to study quality in this sector and its relationship to payments and costs. Our third draft recommendation which I will turn to later, addresses our need for better information in this respect.

The next thing that we can do to improve quality is to improve quality outcome measurement which is still not well enough developed in this sector. MedPAC, CMS, and others are working together to come up with better quality outcome measures. Once we improve the quality measurement then we can measure implement financial rewards for SNFs that provide better quality.

The evidence regarding SNF's ability to access capital is similarly mixed this year. CMS's annual analysis of the nursing home industry suggested that access to capital worsened in early 2003 due in part to uncertainties surrounding Medicare and Medicaid payments. However, nursing homes Medicaid funding situation for this year at least appears to be improving. Recent reports by both the Kaiser Commission on Medicaid and the Uninsured and GAO suggests that Medicaid nursing home rates remained relatively stable

in 2004, although both sources allude to possible changes down the road if states' budget crises continue to worsen.

Finally, some large for-profit nursing home chains reported higher than expected earnings growth at the end of 2003 which also helped the sector's financial outlook. With respect to Medicare payments, nursing home industry analysts generally view these as favorable for the industry.

Now we turn to the Medicare margin. We project the Medicare margin for freestanding SNFs to be about 15.9 percent in fiscal year 2004. I want to note that we just got updated data that may lower this by a percentage point or so. This follows an 11 percent Medicare margin for 2003, a 16.7 percent Medicare margin for 2002, and a 19 percent Medicare margin for 2001. This is for freestanding facilities.

The Medicare margin for 2004 is higher than the Medicare margin for 2003 in part because SNFs received the full 3.0 percent market basket update for 2004 plus an additional 3.26 percent payment increase which represents an administrative action by CMS to

correct for market basket forecast errors that occurred in previous years.

MS. DePARLE: Susanne, so what's missing from this is 2003 is 11?

DR. SEAGRAVE: Yes. I could have put that on the slide. Last year we projected the 2003 margin to be 11 percent, and that's still what we project this year.

MS. DePARLE: And 2004 is a projection as well?

DR. SEAGRAVE: Yes.

MS. DePARLE: But 2002 and 2001 are actuals?

DR. SEAGRAVE: Yes. To give you an idea of the distribution of Medicare margin across facilities, we found that about 88 percent of Medicare bed days in 2001 were in positive margin facilities. The Medicare margin for hospital-based SNFs is difficult to measure correctly because of hospital cost allocation issues, as you discussed in the previous discussion. We estimated the Medicare margin for hospital-based SNFs in fiscal year 2004 to be negative 77 percent. However, we are unable to determine what this number means in the context of an efficient provider.

As we've discussed before, freestanding SNFs generally responded to the SNF prospective payment system by reducing costs. We expect this trend to continue into 2005. Furthermore, although nursing wages may have increased for SNFs in recent years because of the nursing shortage, costs may not have risen by as much as wages to the extent that SNFs substituted lower skilled for higher skilled labor. In addition, data by the Bureau of Labor Statistics suggests that nursing wage growth may be stabilizing.

Finally, we are aware of only one cost-increasing, quality-enhancing technology in this sector, vacuum assisted closure, the so-called wound vac for healing wounds. We do not know the extent to which SNFs are adopting this technology because of the incentives in the SNF prospective payment system.

Finally, we believe these cost changes in 2005 can be accommodated within the margins SNFs already have in 2004. Therefore, we recommend that the Congress eliminate the update to payment rates for skilled nursing facility services for fiscal year 2005. The update in current law is market basket which is

currently estimated at 2.9 percent for fiscal year 2005, and this estimate, of course, is subject to change each quarter.

Within the budget categories that MedPAC has developed, a zero update for SNFs would decrease Medicare spending relative to current law by between $200 million and $600 million in one year and between $1 billion and $5 billion over five years. Because we project the Medicare SNF margin to be 15.9 percent for 2004, we do not anticipate major implications for beneficiaries or for providers of this recommendation.

However, we would like for this overall pool of money to be better distributed across the different types of patients cared for in SNFs. Thus, we reiterate our recommendation from last year which is intended to improve access to SNF care for those types of beneficiaries I mentioned earlier that may be having difficulty accessing SNFS, and distribute money more accurately among providers.

We recommend that the Secretary develop a new classification system for care in SNFs, and because there needs to be a more immediate fix to the

distribution of money in the SNF payment system, the Congress should authorize the Secretary to remove some or all of the 6.7 percent payment add-on to rehabilitation RUG groups and reallocate money to the non-rehabilitation RUG groups to achieve a better balance of resources in the system.

As we added this time again, if necessary action on this does not occur by October 1st, 2004, the Congress should provide an update to payment rates for hospital-based SNFs of market basket minus 0.9 percent adjustment for productivity.

The portion of this recommendation that deals with hospital-based SNFs would decrease spending relative to current law by less than $50 million in one year and by less than $250 million over five years. The other part of the recommendation we assume would be spending neutral. This recommendation as intended would potentially provide better access to SNF care for certain types of beneficiaries and more accurately distribute Medicare payments among providers.

Finally, so that we and others may better study the relationship between nursing costs, total

costs and quality of care in this sector we recommend that the Secretary direct SNFs to report nursing costs separately from routine costs on their Medicare costs reports. Facilities in some states are already doing this. This recommendation has no spending impact, would have no effect on beneficiaries and would likely mean a modest additional cost for providers.

This concludes my presentation and I welcome any questions you may have.

MR. DURENBERGER: Thank you very much. My question is going to relate to quality. The basic question is, we've been talking about paying for performance and things like that, and my concerns -- I've skipped my concerns about cross-subsidizing Medicaid and all that sort of thing so this really relates to whether or not changing payment or increasing payment actually have or can have an impact on integral quality. In other words, if you were going to pay for performance in the sub-acute system, what would you pay for and how would you construct the system? The only distinction I could gather from some of this material, and I may have misinterpreted what you presented was,

pull out the routine cost from nursing costs and some things like that.

But I know the National Quality Forum has been working on measures. I know that Tom Scully thinks he's got measures. I know that he's been advertising that you can call a number and rate this nursing home versus -- but I still don't get what's quality when I -- and I haven't tried to call the number, but I'm still not sure of what the definition of quality is. But more importantly, what role payment or payment policy has as it relates to the quality. Can you help me understand that a little better?

DR. SEAGRAVE: To start off maybe with your second point, I think we are still struggling with what quality means in this sector. I think that's why we still have to develop better quality measurement in order to be able to reward providers that demonstrate better quality.

MR. DURENBERGER: Does that mean better measurements than the ones that allegedly the National Quality Forum produced, or am I misinterpreting what they did last year?

DR. SEAGRAVE: I think in terms of whether the government can use the measures that the National Quality Forum developed, whether Medicare's purpose for those measurements would be the same as the National Quality Forum's purpose, those kinds of things I think still need to be worked out. So I think we're still a little ways away maybe from having the type of quality measurement that we might need to be able to reward quality.

Then getting to your second question about the relationship between Medicare payment and quality, I think there have been many -- I'm glad you brought that up. I think there have been many studies recently about the relationship, not just between Medicare payment but between financial performance in nursing homes specifically and quality. I think that those have shown that the relationship is not very clear, and in fact a recent study showed that for-profit nursing homes in California that have greater than 14 percent margins actually display lower quality in terms of the number of deficiencies that they show. So I think that there's not a clear-cut relationship between payment and quality

and that's why I think breaking out the nursing costs from the total costs and looking at that, and looking at payments and costs and quality relationship, I think more work needs to be done.

MR. DURENBERGER: I'd just summarize by saying, just as a layperson who uses the system for family members, I'm very confused when I hear the word quality being used by the administrator of CMS and a lot of people, and I'm not sure that we really know what we're talking about. Yet when I sit here to try to make a judgment on payment adequacy I'm more inclined to think about quality than I am about access because I think it seems like we've solved a lot of the access problems, or at least some of the access problems, some substantial part of the access problems, but I'm not sure about the quality part. So I'm left unsure about how to deal with that and I would interpret your answer as saying, at the present stage we don't have much to be helpful to you, if that's your questions.

MR. HACKBARTH: In this context where we have high average margins, adding more money to the system is not a very powerful tool for trying to improve quality I

think is one of Susanne's basic points. They've got enough money now. The incentives are to reduce costs. If you really want to improve quality you would be better off identifying what you regard as improved quality and paying specifically for that.

MR. DURENBERGER: That's precisely why I asked the question.

MR. DeBUSK: Glenn, are we adding or are we taking away? You said by adding more money.

MR. HACKBARTH: This recommendation is for no update.

MR. DeBUSK: No update. But the update is designed to keep up with the cost of services provided from year to year, right?

MR. HACKBARTH: And they have average margins of 15 or 16 percent currently.

DR. MILLER: Just a couple other things on the quality point. I'm going to need some help here so if Karen and Susanne can both follow me here. There are people mining the MDS data to look for quality measures and that is part of CMS's effort; is that correct?

MS. MILGATE: Yes.

DR. MILLER: And then there's the notion of nursing home quality measures which I think some other groups are mining those measures. I'm just looking for a nod or a clarification.

MS. MILGATE: CMS is looking at nursing homes too.

DR. MILLER: Just to be clear, that's distinct from SNF. We ourselves are looking at some readmission indicators; is that correct? And we're would going to be doing some analysis on the relationship between cost and quality down the road.

DR. SEAGRAVE: That's correct.

MS. RAPHAEL: I happen to believe that one of the most important areas of quality in nursing homes happens to be staffing, and that while you have a 100 percent turnover rate in CNAs and if you don't have the nursing staff it's just going to be very hard. It's one of the few places where I feel inputs are probably as important as outcomes. So I'm wondering if we're looking at that in the work underway.

DR. SEAGRAVE: Certainly. The CMS web site, they report staffing levels by nursing facility. We're

looking at costs and quality and staffing levels, because I think there have been a number of studies on the relationship between staffing levels and quality in nursing homes. I think we're continuing to look at that and try to find out what's going on there.

MS. RAPHAEL: Do they report retention rates?

DR. SEAGRAVE: No.

MS. DePARLE: As I recall that's really difficult to get.

DR. MILLER: Susanne, that's one of your motivations for the third recommendation, is to try to break out the nursing costs as separate. Not perfect, but to begin to drive in on how much of their resources are going to nursing and whether there's a relationship between that and equality.

DR. ROWE: Carol, when you say 100 percent turnover, if there are 20 nurses --

MS. RAPHAEL: No, CNAs.

DR. ROWE: All right, let's take them. Do you mean that all 20 of them change, or that maybe 10 of them stay the same for years and years and years and the other 10 slots turn over a couple times a year? So

you've had 20 turnovers; i.e., 100 percent turnover, but in fact you still have a core of people who are there for -- what do you mean when you say 100 percent?

MS. RAPHAEL: I don't know for sure because I'm not sure there's consistency in how --

DR. REISCHAUER: It's almost always the latter.

DR. ROWE: That's what I think. So the turnover rates exaggerate the impact a little bit maybe.

MS. RAPHAEL: Although I think they're very high in the first six months from what I remember.

DR. ROWE: When people learn what the job is.

MR. SMITH: Just quickly I want to underscore Carol's concern on the nursing side of this. It's not just a question of nursing costs or share of costs allocated to nursing but something about staffing, something about training, something about turnover, and turnover up and down the hierarchy matters a lot. I think, Bob, you're right that it tends to be some stable, some turnover a lot pattern, but that's not within the same job category. At entry level job categories the absolute turnover is higher and

supervisors tend to be more stable.

Just a quick quibble on recommendation two. It seems to me we ought to make sure that the recommendation says that we're talking about the same money in the second bullet that we're talking about in the first and we don't. We could be talking about two different chunks of money. So it's only the money, or reallocate some of the money or some such change.

DR. REISCHAUER: My question dealt with the same issue. Susanne, I was wondering if we had any kind of feel for if the first part of the recommendation occurred what it would be equivalent to as an update for hospital-based SNFs? I didn't know if these two things are different ways of doing very similar things or one is, let's go for a vacation and if we don't go for a vacation, let's buy a car. Are hospital-based SNFs heavily into non-rehab RUG services or not? Because if they aren't it's sort of like, does this really connect?

DR. SEAGRAVE: I think it's hard to determine -- across the board it's hard to say if they're more into rehab, more into non-rehab, those kinds of things.

I think that the recommendation is designed to more accurately distribute payments among different types of providers, and to the extent that a particular hospital-based SNF treats a higher proportion of non-rehabilitation patients then it is designed to funnel more money to them. But I think it's still an open question whether hospital-based SNFs are treating a higher proportion of non-rehabilitation patients.

DR. REISCHAUER: So it's conceivable that if the first part of the recommendation happened it wouldn't do anything for hospital-based SNFs.

DR. NEWHOUSE: But going beyond that, to raise whether we want the second part of the recommendation at all.

DR. REISCHAUER: It might hurt them. Without knowing that it strikes me that either they should be two separate recommendations or else we should be careful about what we're suggesting.

DR. MILLER: I thought, and again I could have missed something in the process here. I thought that at one point we had some indication when we were looking at case mix differences between the two that there was some

thought that they were more heavily mortgaged in the non-rehab. Is that not the case?

DR. SEAGRAVE: I think we think they are treating a higher case mix of patients. I think that there's some indication, although it is based on older data, that they are treating a higher percentage of non-rehabilitation patient. But getting the more current data and figuring out whether that's still the case or not, I'm basically not willing to go out on a limb right here in front of everybody and say that they definitively are at this point.

DR. MILLER: That's appreciated. But when we drafted this up last year we had some thought in our mind that it would be redistribute it. But you're saying, to be completely careful about it you would want to see the most current.

MR. MULLER: Would you remind me again what the distribution is between the profits and not-for-profits in terms of their rehab share? I seem to remember from last year we had some numbers on that. Weren't the rehab services higher in the for-profits than the not-for-profits?

DR. SEAGRAVE: I honestly don't remember that data from last year. That would be my guess.

MR. MULLER: I seem to remember we had it before so that should be retrievable as opposed to a new --

DR. REISCHAUER: If that isn't the case we have to rethink capitalism.

MS. BURKE: Two questions. One, on the issue of nursing and the third recommendation, which I think is terrific, one of the questions that ought to occur once we actually separate these things out is some understanding of what we mean and the differences in what nursing is. Nursing costs as stated will include a broad range of what are defined as nurses. The question, and in fact there is research on this topic and some data available on the impact of the presence of professional nurses. Is that the word we use now? Registered nurses, whatever the word is that we currently use, that there is in fact a direct impact of the presence of registered nurses as compared to a broader array of nurses.

So one of the things I would hope we'd be able

to do as we develop this information, or if we can understand if there is in fact that difference, is it just nurses, nursing cost, money spent on X more LPNs or X more aides, or is it in fact -- does it differentiate if in fact the money is spent on fewer but they are registered nurses as compared to nurses aides? Just for purposes of understanding what that impact intent is.

The second question is, at the risk of getting back into the conversation about margins, nonetheless on page 14 we again avoid the obvious question and the specifics by stating that the aggregate Medicare margin for hospital-based SNFs remain slow. What I think I heard you say was that it's negative 77 percent. That is certainly a definition of low. But again, they will ask the obvious question and the question is, do we address it directly or do we not? But I think just simply referencing low and a statement of margins that are in the 15 and 16 percent, whatever it is versus a negative 77, one might think we might want to explain once again that there is a number there that is not a number we're solid with. But it will just lead to the inevitable question, what does low mean? You've stated

it affirmatively for freestandings. We know what it is. What does that mean?

So again, I don't want to get back into that debate but I think we need to be -- the question is going to come so we may as well be prepared to deal with it one way or another.

DR. NEWHOUSE: I was going to let Bob's other shoe drop. Should we take out the last part of two, not only because we seem to lack data but also because even if we had data showing differences, as Bob said on the home health, it's not clear we would want to pay for it.

DR. REISCHAUER: My question is whether we shouldn't break up recommendation two. The first part of it seems to be, let's get the distribution of payments better. We don't know if that's going to help hospitals or isn't going to help hospitals. But if we think there's a problem in hospitals then we should have a recommendation saying hospitals should have some kind of an update. If we're concerned about the overall level what we should say is, we should take the 6.7 percent payment add-on, take a chunk of that to

distribute across payment categories to make them better, and take another chunk of it and use it for a hospital-based SNF update.

DR. NEWHOUSE: Why do you want to do the latter?

DR. REISCHAUER: Why do we want to do the latter in this recommendation now?

DR. NEWHOUSE: I don't know.

DR. REISCHAUER: Presumably because we think --

MR. SMITH: This recommendation at the moment, Glenn, I had wanted to go to the same place -- suggests that we know something about the distribution of non-rehabilitation patients, that they are skewed toward -- otherwise this recommendation doesn't make any sense. We're going to shift the money from rehab groups to non-rehab groups, but if we can't, we want to give money to hospital-based SNFs. We have to assume, Mark, that there is a distributional of relationship as your remembered, but we don't recite it anywhere here and there's been -- this discussion makes me wonder whether or not the only recommendation that we really have any

grounds to make is the last part, I think which is where Bob was going, the last part of what is now two. To remove the 6.7 doesn't make any sense.

DR. MILLER: If I could just say one thing on the 6.7, regardless of what we thought was going on in hospital-based, we believe that the system as it's currently constructed in terms of the relative weights the money should be redistributed, and that the money will better track the patient. So regardless of where they ended up, hospital-based or non-hospital-based, we think that should happen, on the basis of analysis that we've done of the payment system.

Now rightly or wrongly last year -- and I'll take responsibility for this -- in looking at case mix we thought there may be something to the story that they may be taking more of these patients, and made the point that this redistribution may help those hospital-based SNFs. I think Susanne is beginning to say, I need to be sure that that's still the case so we may be walking away from that.

I think this recommendation, the redistribution stands on its own merits. We've been

over this ground. I think the question becomes what to do about the second one.

MR. SMITH: But the second one is now offered as an alternative to the first one, suggesting that we're trying to accomplish the same thing. We clearly shouldn't do that.

DR. MILLER: The linkage should not be there. I agree with that.

MR. SMITH: So if there's a justification for the second half of recommendation two as drafted it is that we think that hospital-based SNFs are in some trouble.

MS. RAPHAEL: But the rehab data, as I remember, showed they had shorter length of stay and higher case mix and higher nursing staff. That's what I remember. I don't remember information about rehab and the degree to which they provided rehab.

MR. SMITH: No, but I think that's exact -- or at least we're uncertain about that, Carol. So that suggests that even if we accomplish the desirable redistribution among RUG groups that we have to then ask ourselves, do we have an institutional issue here which

suggests that for whatever reasons hospital-based SNFs need additional resources? I don't know that we've made that case here.

DR. NEWHOUSE: I want to go back into history. In the early 1990s entry conditions for hospital SNFs were especially favorable. You could get your costs back, and they expanded very rapidly. What we've seen post-BBA is a considerable contraction in the for-profit hospital SNFs, which just suggests to me that for-profit firms were pursuing profit in the early '90s. BBA took it away and they exited. It's not clear to me that there's anything bad at the end of the day from all of this.

I think there's a downside to this recommendation even beyond trying to fix up the SNF side in a way that may or may not be very good, which is that we're going to reintroduce differential payment rates according to site of care, which is, I think, a principle we don't want to do.

MR. HACKBARTH: So, Joe, your proposal would be to drop this --

DR. NEWHOUSE: To strike this last clause and

go with the first part.

DR. REISCHAUER: To be fair, what we should do is split them and vote on it, rather than --

DR. ROWE: With respect to your historical, I think payment had something to do with it, but one of the other things was that length of stay was falling in hospitals. Occupancy rates were way down. There were lots of empty wards. There were resources in search of needs. There were people trying to figure out how to use those facilities, and that fed a lot of the development of hospital-based SNFs.

DR. NEWHOUSE: The one reason length of stay was falling was one could unbundle the DRG payment, put the marginal day over in the SNF.

MS. BURKE: I'm perfectly comfortable splitting these. I think that makes perfect sense. But before outright rejection of this last question, and not necessarily this proposal but the issue of hospital-based, I think some thought -- I'm almost hesitate to suggest we even vote on this. I wonder if we shouldn't set it aside rather than defeat it, and get a better understanding of what the issue is that we're trying to

deal with. There are geographic issues. There is a predominance of these folks in rural areas. What implications that has, I don't know.

Joe's point about the rapid increase in the number of home health agencies in the early '90s is absolutely right. Whether or not what remains are predominantly for-profit, whether it's just all the for-profits that have left that would suggest it's just a question of whether there's profit or not, I don't know the answer to that question without looking at -- but Joe may have a very good point.

But I think there's an issue here, a minus 77 percent margin would suggest there is an issue. I guess my preference would be to understand that more clearly before we reject out of hand that there's initiative there that needs to be dealt with.

MR. HACKBARTH: I agree with that, Sheila. Rather than defeat it on an uncertain factual basis I would just say, let's take it up at a later date, get some more facts and set it aside for now. So the proposal on the table would be to vote on the reallocation proposal only.

MS. BURKE: Could we accompany that -- what I would also not want to do is leave it unstated that there is an issue at least the Commission is interested in pursuing, and that while we have not adjusted in those go-round that it is our intention to examine more carefully. So I think the document ought to reflect, the issue has arisen. We chose not to address it here in the absence of information, but in fact we specifically intend to do so.

DR. SEAGRAVE: Can I just add to this conversation just quickly? We have two major research projects going on right now with outside contractors, both of which are devoted to studying hospital-based SNFs and what happens in areas where hospital-based SNFs close, and what the products that hospital-based SNFs are delivering is. So we have that, plus we are also doing a really serious look at hospital-based SNF costs. So all three of those.

DR. WOLTER: This would be anecdotal, but in my own experience with hospital-based SNFs in my part of the world in fact the physicians putting patients there are choosing patients they wouldn't send to freestanding

SNFs because in their assessment they're more fragile, need more resource. Also I would say, and this is just my own institution so it's an N of one, we have different standards around nursing ratios and mix of nurses and those sorts of things. So I think that at least in some cases there is probably something different going on.

Then back to this overall Medicare margin discussion, if we're concerned about hospitals' overall Medicare margins, how do we decide to fund a full market basket in inpatient and outpatient versus SNF versus whatever? That's why I'm a little bit concerned about where we're headed with this, because it may be that in fact the overall Medicare margin in hospitals is in some decline in part related to their SNF margins as opposed to inpatient or outpatient. So I worry a little bit about how we make these decisions as we start lumping everything together.

MR. HACKBARTH: What we can say is that as a proportion of the overall book of business, the hospital-based SNF is a very small fraction of the total. I don't know those numbers off the top of my

head but it's just a couple percent.

DR. SEAGRAVE: 2 percent.

MR. HACKBARTH: About 2 percent. So it can't be a principal driver of what's happening to the overall margin. It's just not big enough.

MS. RAPHAEL: I'm sure all of us have received a lot of material and I just read some of the material I received from so of the people in the nursing home sector and they made the point, which I just think we should go back and check and I will give to you, Susanne, that they are already reporting nursing costs apart from routine costs in line 16 of some form, and all the rest of that. I'll pass this on because we just ought to confirm that it's not --

DR. SEAGRAVE: I'll tell you that I've spoken with some experts on the SNF cost report and I and the experts I spoke with do not believe that's what's currently being reported or what is going to be reported on the SNF cost reports, is getting at exactly what we want to understand. So I'm actually going to discuss that with --

MS. RAPHAEL: We should put it in the text

probably too.

MR. DeBUSK: Nick, in the allocation of overhead at your institution is that not done on a square footage basis? So a nursing home owned by your operation, it could be sizable then, right, from a dollar standpoint?

DR. WOLTER: In our case the SNF is located on-site so it's the size of a nursing unit in essence.

MR. DeBUSK: You say that's 2 percent?

MR. HACKBARTH: We're talking about overall. Not all hospitals have hospital-based SNFs, but --

MR. DeBUSK: Yours could be considerably higher then, right?

DR. WOLTER: This whole accounting issue, I believe needs to have a little light shed on it. I would just say this, I don't think that we're doing any arbitrary allocation of costs to SNF or anything outside of inpatient. It may well be, however, that our overall overhead for the institution, the indirect costs, are higher than it might be for a freestanding, smaller operation. Therefore in the allocation methodology more costs end up getting allocated. I assume that's at

least part of what goes on. But I just can't come up with any information anymore suggesting that hospitals are arbitrarily allocating costs from inpatient to outpatient. I just don't see that in my life.

DR. NEWHOUSE: When I said arbitrary, I meant just a convention that could be a different convention that would lead to a different allocation. So square footage, in my view, is an arbitrary way to allocate cost. It can be consistent over time, and that's the rule. You could allocate it in some other fashion that would lead to a different allocation. I would go on and add, if the Commission pursues this, I think it ought to try to get some measure of direct costs for these various lines of business. That is, the costs before any allocations are made. That I think would be -- that has some meaning as a number to look at.

Now the indirects have to be covered in some fashion, which gets you to the most-of-Medicare margin, but that's not what we have now.

MS. BURKE: Can I ask a question? Remind me what we do with swing beds currently.

DR. SEAGRAVE: The swing beds in critical

access hospitals are not covered under the PPS, and those are not included. I believe other sorts of swing beds were first included in the PPS, I believe starting in 2002, so our data for the most part still has not included them. I'm not sure what we're going to do about them next year. I'm not sure if they're going to be somehow -- anyway, the short story is I don't think they're included in our analysis at the moment.

MS. BURKE: And the prevalence today swing beds? How many hospitals actually --

DR. SEAGRAVE: I could get back to you on that. I don't know that --

MS. BURKE: I don't know whether their experience will lend us any knowledge about the nature of the hospital-based nursing home patient. I mean, understanding what they look like, how they're dealt with. Arguably, they would be comparable, presumably, to any other hospital-based unit, skilled unit. It's just the hospital's choice of how one structures. But I don't know whether any understanding -- just as you're looking at this issue and giving the studies that are going on, I don't know whether that would inform us at

all, but it would be interesting to know what the nature of those folks are and whether there's any comparability.

DR. SEAGRAVE: I will tell you that what I've heard a lot of people say, particularly actually in rural areas, is that it's easier for them to, perhaps to close their hospital-based SNF and just have swing beds. that makes it easier administratively.

MR. HACKBARTH: Last comment.

DR. REISCHAUER: Just a question. What happens in critical access care hospitals? The SNF is a separate unit, right? But we're talking about possibility in the past of shifting administrative costs onto the cost-based reimbursement and now we've gone the other way, so you could see a lot of the administrative costs --

MR. ASHBY: In the past they have not been allowed to have SNFs so it really hasn't been an issue for critical access hospitals. They do have swing beds, of course, so it's the same issue.

MR. HACKBARTH: Let's go back and vote on the recommendations. All opposed to recommendation one?

All in favor? Abstentions?

All opposed to recommendation --

DR. NEWHOUSE: Just this much of it?

MR. HACKBARTH: Just this much. We're dropping the part about the market basket increase for hospital-based SNFs as an alternative. So it's just this piece.

All opposed to this? All in favor? Abstain?

I think that's it then, right?

DR. NEWHOUSE: Number three.

MR. HACKBARTH: That's right. All opposed to number three? All in favor? Abstentions?

Okay, thank you.

Last up is inpatient and outpatient hospital services.

MR. ASHBY: Good afternoon. This is the hospital session. I'm going to begin this session by presenting overall Medicare margin data which support our assessment of payment adequacy for the hospital as a whole. Extending beyond the data that we presented in December, this time we'll be including information on margins by hospital group and data on the distribution

of margins. Then Julian will address payment adequacy as well as our draft update recommendation for inpatient services, David will briefly update our information on access to capital, and Chantal will present outpatient margin information and our outpatient update recommendation.

This first chart shows overall Medicare margins for 2000 to 2002, and our estimate for 2004 which reflects policy changes that occurred between 2002 and 2004, and also the impact of policy provisions in DIMA, or MMA, if you prefer, that were scheduled for implementation in either '04 or '05. You'll notice that the margin estimate for 2004 is 1.8 percent while the estimate that we reported to you in December with 2.8 percent. Unfortunately, most of this change resulted from a mistake that we made. The mistake didn't affect any of the six component margins. Rather, it involved the process that we use for weighting the six component margins to arrive at the overall Medicare. We apologize for the error.

In addition to our mistake we also discovered a problem in CMS's cost report file. We corrected for

the bad data through imputing and that lowered our estimate of the outpatient margin that we presented in December, and Chantal will, a little later, give you the details on that.

Now onto the values. We see in this chart, obviously, that we have a small reduction in margin in '01, a larger reduction is '02 and essentially no change to '04. Unusually large cost increases were instrumental in both the '01 and the '02 decreases in margin, but in '01 the cost increase was offset somewhat by an increase in DSH payments that was mandated by BIPA and a large increase in outpatient payments that followed the implementation of the outpatient PPS.

After '02, the almost constant margin represents the net effects of a substantial increase in payments from a number of DIMA provisions and CMS's tightening of inpatient outlier payments. Excessive outlier payments pushed total inpatient payments nearly 2 percent higher than was intended in 2002. Our simulation for '04 assumes that the system reforms that CMS implemented will return aggregate outlier payments to the targeted level. It's quite possible that within

that time frame outliers will not drop all the way back to the target level, in which case the margin estimate that we have shown would, all else equal, be too low.

At the December meeting we provided the estimate that Medicare inpatient cost per discharge rose by 6.6 percent in 2001. That was the highest increase that we have seen since the early '90s. But we wanted to point out that the increase in cost per unit of output across all services that hospitals provide is somewhat lower.

Our all-service measure that you see here known as cost per adjusted discharge shows a 5.0 percent increase. This calculation is for all payers. Data limitations prevent us from putting together a measure specific to Medicare but we do at least have strong evidence that the Medicare figure is substantially less than the 6.6 for inpatient alone. For 2002, again our preliminary data show that the rate of increase is lower when calculated for all services than for inpatient alone.

The next chart summarizes some of the key factors causing the unusually large rate of growth in

per-unit costs. In this analysis we're looking at all costs. That is for all services across all payers. We found a major impact from increased labor costs, including both increases in wages and benefits and increases in use of labor, and that the increases were concentrated particularly in the area of nursing personnel. But as we talked about in December there is already evidence that the rate of growth in labor cost is abating. BLS data show that hospital wage and benefit increases peaked at about 5.5 percent in 2002 and that increase was down to about 4 percent by the third quarter of 2003. That's actual data through the third quarter of 2003.

Similarly, hospital employment increases peaked in 2002 at about 2.8 percent and they were down to about 2 percent by the third quarter of 2003. Then we had smaller impacts from drugs and chargeable supplies, and that would include devices, malpractice costs and capital expenses. On the drug issue, the rate of interest in overall drug spending has moderated somewhat in '03 but we're not really sure how that played out for drugs provided in the course of hospital

care. Malpractice costs tend to be very cyclical, so the unusually high rate of growth that we saw in 2002 is bound to moderate at some point in time.

The rate of capital cost growth on the other hand may very well rise in 2003 and beyond given the ample evidence that we have expanded capital investment. But Medicare capital payments are not intended to draft new capital investment year to year. Given the capital cycle, hospitals should expect lower margins for a certain period of time following a major capital project, and all else equal they would receive higher margins in the later part of the capital cycle.

The third factor is reduced financial pressure from private payers. We have ample evidence that private insurer payments have gone up faster than costs in each of the last three years and that the increase was particularly great in 2002, the year of the high cost increases. This factor may have enabled higher cost growth, higher growth in unit costs than otherwise would have occurred.

The next chart focuses on changes in margin between 2002 and 2004 by hospital group. Again, the

2004 figure reflects the provisions of DIMA as if they had been in place in 2004 and also changes in policy occurring between '02 and '04. I need to begin here by noting that we couldn't model two of the provisions of DIMA at the group level so all of the group-level margins in this table are understated by an average of about 0.4 percent. The two provisions in question here are a one-time opportunity for hospitals to appeal their wage indexes, which CBO has estimated will bring $300 million into the payment system, and also liberalize payment policy for critical access hospitals.

There are 234 hospitals that our simulation suggests would still have negative overall Medicare margins after accounting for the provisions of DIMA and that could otherwise meet the qualification criteria for CAH, so we modeled the impact of these facilities leaving the PPS. The right-hand column though shows that two groups in particular, the overlapping rural and non-teaching hospital groups would likely receive most of the benefit from these two provisions.

Now as for the changes by group, the drop in margins for urban hospitals primarily reflects the

impact of tightened outlier payments together with a modest increase in payment from DIMA. Rural hospitals, on the other hand, benefit tremendously from DIMA, as was intended, but they receive little outlier payments so they were not affected much by the tightening of outlier policy.

Then major teaching hospitals, again, their drop in margin primarily reflects tightened outlier payments, and that brings us to the non-teaching hospital group. Of course, this group includes almost all of the rural hospitals whose payment increases were substantial under DIMA, but urban non-teaching hospitals account for about 70 percent of the payments in this group. Urban non-teaching hospitals benefit from some of the DIMA provisions but then, as in the future under current policy, they receive none of the IME payments above the empirical level and their DSH payments are below average as well.

On the distribution of margins, in 2004 and reflecting the impact of DIMA provisions, we estimate that about 50 percent of hospitals will have a negative

margin. And using the weighted measure, that is the percent of payments that go to negative margin hospitals, the figure would be about 46 percent.

MS. BURKE: Could you repeat that?

MR. ASHBY: This is 2004 reflecting the impact of the DIMA provisions. At that point we estimate that 50 percent of the hospitals would have a negative margin, but if we did it on a weighted basis, 46 percent.

MS. BURKE: I guess I'm trying to equate that number with the numbers that we see before us and I just want to make sure I understand. These are the margins by type of hospital?

MR. ASHBY: Right, these are aggregate margins for the hospitals in each group.

MS. BURKE: And overall it has an estimate of 1.8.

MR. ASHBY: Right.

MS. BURKE: What you're suggesting is, if you were to dial that down, that half the hospitals would be negative.

MR. ASHBY: Right. And within each group it's

worth noting that there's quite a wide variance and a significant portion of negative margin hospitals in every one of these groups.

MS. BURKE: The other question that I would have, given the discussions around the nature of the non-teaching hospital and what we now understand in terms of what this distribution is going to look like in terms of margins, is there value -- and I'm prepared to have somebody say it doesn't make any sense because we don't do it any place else -- is there value in looking more carefully at that category, and for example, splitting out urban non-teaching versus rural non-teaching? We have those as separate categories. But because that is the one place where there are margins that are overall negative is there a value in splitting out what that looks like?

MR. ASHBY: There certainly would be. We have now looked at non-teaching separately for urban and rural since the impacts are quite different. The rural non-teaching, the margin would be very close to what you see for rural, because almost all rural hospitals are non-teaching. The urban non-teaching margin would be

minus 3.1.

MR. MULLER: We discussed this last month but what inflators were you for using for 2002 to 2004? You made the point in your presentation earlier that -- you had the 6.6 and the 5 percent, the 6.6 for inpatient and 5.5 for overall. But what are you using to go from 2002 to 2004 to get to your '04 estimate?

MR. ASHBY: We're using market basket minus half of the productivity standard.

MR. MULLER: So roughly around three.

MR. ASHBY: Roughly in the neighborhood of three.

MR. MULLER: So if it's in the five range, then the 1.8 could be an overestimate. I mean, by definition it would be an overestimate.

MR. ASHBY: Yes, pretty much, by definition, right.

MR. MULLER: As I think we discussed it -- I don't want to go through the whole thing again as we did last month, but at last for probably '03 we can all see next year where we come out on these things but my guess it's going to be closer to five than three, so that

could throw even more of the hospitals into negativity if the 1.8 --

MR. ASHBY: But keep in mind that we have a 5 percent figure approximately in 2001 and with the evidence that the rate of growth has come down I'm not sure that we will be much off of three. We might to some degree. There is indeed some risk here; there's some uncertainty. But there's also uncertainty on the payment side. It's quite conceivable that the outlier impact, we have assumed that all extra outlier payments go away, and we're not at all sure that that's really going to happen. And some of the DIMA provisions -- again, we're not exactly sure how those are going to play out, so there's a great deal of uncertainty here but it's not entirely clear that it's going to be higher, much higher than what we've shown.

DR. WAKEFIELD: Jack, when I'm looking at the estimated '04 rural, a little bit to Sheila's point earlier, and the non-teaching category of minus 1.6 and trying to get as clear a fix on what that category of non-teaching looks like since it seems to be doing the poorest here of all the different categories, Sheila was

asking about might there be difference by rural-urban, for example, and you said, yes, the urban non-teaching probably are minus 3.1 and the rural non-teaching is going to be a lot closer to 2.3. That 2.3 includes CAHs in it; is that correct?

MR. ASHBY: No, it does not.

DR. WAKEFIELD: So it's non-CAH --

MR. ASHBY: This entire analysis is non-CAH.

DR. WAKEFIELD: Not just the '04 CAH, which is what your asterisk says.

MR. ASHBY: Exactly. All of the figures are exclusive of CAHs that we knew about at the time of the analysis which is 835.

DR. WAKEFIELD: My apologies. I misread your asterisk, because it mentions DIMA so I thought everything prior to DIMA CAH would be included. But you're saying no.

MR. ASHBY: Exactly.

MR. MULLER: The estimate we had for 2002 last year, do you happen to remember --the 1.7 we're showing now -- do you remember what we estimated for 2002 at this time last year?

MR. ASHBY: We estimated 3.9 percent for 2003 last year. That's what we were estimating at the time. We didn't have an estimate for 2002.

MR. MULLER: So we did make a gap estimate?

MR. ASHBY: No. As we don't have an estimate for --

MR. MULLER: I understand that. But in a sense you must make one because --

MR. ASHBY: No, actually we don't. It's far easier not to estimate the middle one because then you don't have to analyze things that went in and came back out and so forth. You can just look at one set of policies.

MR. PETTENGILL: The information that Jack has just given you is relevant to two important questions. One is whether Medicare's current aggregate payments are sufficient to cover hospitals' cost of furnishing care to Medicare beneficiaries. The other question is whether those payments cover costs consistently across hospitals.

As you think about these questions though, it's important to take into account the evidence that we

presented back in December on the other indicators that we use in the payment adequacy framework, and those are shown on this slide here. To briefly recap the findings, first, we found no evidence of any deterioration in beneficiaries' access to care based on providers participation in the Medicare program, on changes in their capacity to furnish services, or on beneficiaries' use rates.

Second, the volume of inpatient and outpatient care has continued to grow. No evidence there.

Third, we saw mixed evidence on the quality of care with some improvements but also some important problems remaining. However, there's no discernible connection between Medicare's payment rates and either the improvements in quality or the problems that we identified. So that evidence really doesn't tell us very much.

Available information also suggests that access to capital remains adequate although the cost of capital varies among hospitals. Now since the December meeting some additional reports on hospitals' creditworthiness and access to capital have come out and

those reports have led some people to suggest that access to capital has been deteriorating or is about to. We've been looking into that and David is now going to summarize our findings.

MR. GLASS: Thanks, Julian. This is just a quick update to what we talked about in December. We mentioned then that construction spending was strong and here's some quantification of what that means. It means a 20 percent increase from 2001 to 2002 and 11 percent from 2002 to 2003. Or in dollars terms we're talking about going from about $12.9 billion in 2000 to $18.5 billion in 2003. So the strong growth seems to represent some real confidence in the sector in the capital markets.

That's not to say that every hospital has terrific access to capital or is spending at this rate. As one of the analysts pointed out, there are hospitals that have weak market positions, that have major management problems, and have uncontrolled costs. They may have a problem accessing capital but changing Medicare payment rules probably won't fix it.

Now the other question is, is capital spending

sufficient to replace depreciating assets, even though we can see that as very strong? There was recently a report by HFMA that looked at this question and they compared the acquisition of fixed assets, buildings and fixtures and major movable equipment, to reported depreciation and amortization expenses for Medicare cost reports over five years from '97 to 2001. They were concerned that 40 percent of the hospitals had an index value using that formulation of less than one.

But these individual hospital numbers may not be very informative. For example, it really depends on where the hospitals are in the construction cycle. A hospital that was new in 1996 would have extremely high depreciation expenses and presumably very low acquisition costs for the next couple of years. So it would have a low index value but it would be a brand new hospital. So they may very well have been modernizing it at least the appropriate rate, and it certainly didn't lack access to capital.

Conversely, an old hospital with low depreciation expenses might spend a lot on fixing the roof and that sort of thing and have a high index but

not be in particularly good shape. So the individual values for this index that they introduced may not be particularly informative.

But using the data in that report we found that in aggregate the index was 2.2. Because the update is concerned with the level of aggregate level of dollars in the system, that would seem to be a better indicator for capital access and spending. It would say that it's over twice the depreciating assets. That's it for access to capital.

MR. PETTENGILL: Now taking the margin estimate and the information you've just heard about the other factors, the other indicators, we believe that suggests that in the aggregate Medicare's payments remain adequate in fiscal year 2004.

That brings us to the second stage of the update framework. As shown on this slide, this update will apply to Medicare's inpatient operating payment rates. Given that aggregate payments are currently adequate, the issue is how much efficient hospitals' inpatient operating costs should increase in 2005, not counting any changes in volume or case mix which the

payment system adjusts for automatically? Under current law the update is set equal to the projected increase in the market basket index. There's also a provision that provides for a 0.4 percent reduction for hospitals that fail to furnish quality data.

Now the update framework provides a useful guide for developing a recommendation because it takes into account whether payments are currently adequate, projected in changes in input prices, our policy goal for productivity gains, and our allowance for the effects of cost-increasing but quality-enhancing new technologies.

However, at the end of the day the update recommendation is a judgment that you have to make every year. It is informed by the update framework but not dictated by it. This year we're facing a lot of uncertainty as a number of people have noted, Jack and others, and it's not clear how much efficient providers' costs will have to increase in 2005 because that will depend on what happens to labor costs, what happens to costs for drugs and supplies, and malpractice and capital.

Similarly, it's not clear what will happen with payment growth. There's a lot of uncertainty there regarding the outlier policy, as Jack mentioned, and also about the impact of a number of provisions added by the new legislation, some of which are particularly uncertain and we've mentioned most of those: the wage index reclassification, particularly the one-time reclass, what happens to critical access hospitals, how many further hospitals drop out and obtain critical access status, and also payments for new technologies.

Given that, we're taking that into account in offering the draft recommendation that is now shown on the screen. We believe that a reasonable judgment might be that efficient providers' costs will increase by the full rate of increase in the market basket index. Although we still expect efficient providers to make productivity gains, the judgment is that there may still be strong cost pressures operating that would be sufficient to overwhelm at least a part of that and, thus, a prudent course of action would be to recommend a somewhat higher than usual update that would be suggested by the framework. That's reflected the draft

recommendation.

Now because it's consist with current law there would be no spending implications, nor any implications for beneficiaries and providers. That's that.

DR. ROWE: Can I ask a general question about -- whenever we go through this we always hear from the industry, and I'm sure it's accurate, yes, the average hospital did so-and-so but their Avogadro's number of hospital that did very badly or are on the brink of suffocation, which may be true. I believe it. You give us numbers which are mean numbers and you talk about adequacy in the aggregate, is the term you use, in terms of access to capital, in terms of X or Y or Z. I think this is just worth a minute or to of conversation because I think everybody's right. These data are right, but the concerns about the vulnerable institutions are valid also, and not all hospitals are the same.

MR. HACKBARTH: I think you may have been out, Jack, when they reported some information about the distribution of winners and losers. Do you want to just

quickly --

DR. ROWE: I'm familiar with -- I didn't hear this. I was out. I apologize. But I've seen the distribution. I guess my question is, what is our policy? What is the relevant data that we make our decisions on? Is it the mean, the median, the standard deviation, one standard deviation below the mean? In other words, is there some way that we can act in order to take into account the variation?

MR. HACKBARTH: I'll do the general version and then let them do the more technical version. We focus in the first instance on the average margin. But in recent years I think we've paid in fact particular attention to the distribution and who is losing and why. At least the last couple years when I've testified on the Commission's report we've gone through this with members of Congress and the basic point I've tried to convey to them is that increasing the update for all hospitals is an inefficient tool for dealing with problems particular to certain types of institutions. We are far better off trying to identify why particular institutions are, as a class, losing money and

addressing those issues specifically as opposed to just increasing the update for everybody.

So that was the philosophy, the way of thinking that was, for example, behind our rural recommendations in the June 2001 report. We concluded, based on analysis, that in a variety of different ways rural hospitals were not being treated fairly, if you will, by the system and made recommendations to fix those problems.

So I think our record is one of looking at both the average and looking at the distribution and trying to target solutions where there are identifiable problems.

DR. ROWE: I'm with you 100 percent but then when we get to the recommendations it doesn't reflect anything about that. Now it may be that the distribution currently is not one that meets yours or ours or the staff's or anyone's threshold for doing further analysis, singling out a particular group as it was with rural in the example you give.

MR. HACKBARTH: I think that as some of the questions have already have indicated it would be

worthwhile to look at the non-teaching category some more and try to understand what is going on there. I want to be clear though that this is not a results-oriented analysis. I don't think we want to fall into the trap of saying, this category has a negative margin, therefore we ought to just increase payments to them. What we did in the case of rural hospitals was analytically look at how the system adjusted for various factors and conclude that they were inappropriately, unfairly being hurt. It wasn't just that they were losing money. The system wasn't sufficiently refined to deal with their unique characteristics.

So we don't want to just create a new non-teaching category that has a special update factor, a special payment adjustment just because they lose money. That would be a mistake in my view.

DR. ROWE: One final question on this, and I find this helpful and I hope others do, is when we look at an individual subset or subsets of a population of doctors or hospitals or nursing homes or SNFs or whatever and we see that they're disadvantaged, not that just their results are underwater but that they're

disadvantaged because of whatever, then do we have a policy with respect to the budget neutrality or not of recommendations we make with respect to fixes for that set of institutions?

MR. HACKBARTH: I think we've addressed those issues on the merits and individual cases. For example, if it's an issue regarding the accuracy, the appropriateness of the wage index. inherently we're talking about an index that has relative values, so we tended to say those should be budget neutral changes and not new money. But there are other instances, for example, the DSH payments, where we made a recommendation for new money to be added to the DSH formula for rural hospitals.

DR. REISCHAUER: To the extent that the aggregate margin seems to be more than adequate, then the fix would likely be one that was budget neutral at least.

DR. ROWE: I just think it's worth reviewing a little since we're faced with this distribution issue.

DR. REISCHAUER: But there is this distribution issue which is, what if the 10 largest

hospitals in the United States had, or the 50 largest had margins of 3,000 percent and everybody else was negative, would you be happy? No.

MS. BURKE: A couple of questions and then just a concern. Julian, I want to understand -- actually, let me state the concern at outset. I think one of our challenges this year in the overall presentation in the report will be some framework that allows people to understand why we would look at the response in each sector somewhat different. In some cases we did market basket, in some cases we did market basket minus productivity, in some cases we did something else. That issue occurs to me particularly when you look at this, and actually Nick raised it a little bit in the context of how do you segregate out SNFs or home health from the broader question -- in the context of productivity.

In each of the prior discussions the presumption is that productivity, that there is an adjustment for productivity that is relatively uniform across the sector. We come to hospitals and in fact, as I understand the recommendation, we make no adjustment

for productivity. That is one piece of this broader concern of mine that we are going to have to explain to folks who will look at this and say, why in this case did they decide that because there is uncertainty -- I mean, I think a lot of the conversation here has been quite helpful, but there is uncertainty in everything. There's nothing certain about anything that we've talked about all morning.

So every other sector is going to be equally as confused about a lot of the changes that are coming into play and a lot of the other dynamics. So I think it's going to be incumbent upon us to help people understand why this in fact is different, why the recommendation here doesn't have a productivity adjustment.

MR. MULLER: I heard Glenn say that if you have a margin of 15 it's okay and if you have a margin of 1.8 then -- I mean, if you have a margin of 15 then there's some room.

MS. BURKE: But what concerns me is not just about the margin. That would be the natural presumption, here's a margin of X so you can take this.

There's no magic margin number as far as I can tell, and I think looking in from the outside, we have the benefit of enormous conversation and tremendous input by the staff, but when you look at it free of that I think it is incumbent upon us to give people some sense of it's not just the margin. It is a whole series of considerations that have to be taken into play when we look at these things. But this one will look odd in some respects as compared to the others, particularly around productivity in the broader question.

So I just think as we think about how we say this, whether it's in the introductory document, whether it's in the language we use in each of these sectors, I think we have to be very careful that we don't confuse people further, and that the natural presumption will be, if the margin is X then the answer is Y. Because it's not that directly related. It's a broader context I think.

MR. HACKBARTH: Let me just make a couple of quick comments and then I'll let some other commissioners jump in. Here's my thinking on it.

First of all, I want to be clear that the fact

that the recommendation is for a market basket for hospitals this year, people should not read too much into that. They should not read into it that this means that hospitals will not ever -- forever more be subject to a productivity adjustment. The reason that I feel like this appropriate this year, or several reasons actually, one is that we've seen a fairly significant decline in the average margin to a level that is low compared to other sectors.

Second, there is I think always uncertainty, but maybe a little bit more uncertainty than usual in this case about both the cost and payment trends, for all the reasons that Jack has described.

Third, in the case of this sector we have a distribution of margins that has a fairly high number of institutions with negative margins. Frankly, that was a bit of a surprise to me. I had anticipated that as a result of the reform legislation that we might see a reduction in the number with negative margins, but we have not.

So for those factors in combination, which I think are unique to this sector, I think it's a prudent

step to go with a market basket increase this year for both the inpatient and outpatient hospital services. But again, I don't think it necessarily means that we won't be back next year saying that there should be a productivity adjustment.

MS. BURKE: I have no confusion about the fact that each of these decisions is unique to this year and each year is a different year. I in fact am fully supportive of this recommendation. So this is not because I'm concerned about what's being proposed. I think it makes perfect sense.

It is really about helping people that don't have the benefit of this conversation to understand why there is consistency in what appears to be an inconsistent set of decisions. Why in fact it makes perfect sense for exactly the reasons you suggest. I think it is simply incumbent upon us -- I think we presume that people know or understand perhaps more than perhaps they do when they read what it is that we've said. I think this year particularly we have to be careful about creating the right understanding of what our intentions are and why we got where we got. It's

just the one further step to explain the decisions. But I am perfectly comfortable with the decision that's been proposed.

MR. SMITH: Let me follow up on Sheila in a slightly different direction. I have a hard time reconciling the data that Julian summarized on the seventh slide with the recommendation. It is partly, I think, and something we've talked about before of whether or not the Medicare margin data tells us less than we think it does. We implicitly here, and I think this was what was troubling Sheila, while we having targeted margins in any sector we clearly have concluded that there's some level of margin that's acceptable and when you get below it we begin to get nervous, and in this case our nervousness is reflected in not applying the productivity adjustment to the inpatient and outpatient update that we've applied in other sectors.

If Julian's summary of the access, quality, service volume data, that ought to tell us there's nothing obvious to worry about here. There is uncertainty, but there's not something going on on either the beneficiaries' access to care or the quality

side which suggests that prices are wildly out of line. Instead we've fallen back on this unstated assumption that there is some level of Medicare margin that is too low. It's unstated because we don't have the vaguest idea what that is. This is instinct. I don't think that works.

The other question -- people are tired of me raising it so I'll do it briefly -- is it does make me wonder whether or not the Medicare margin is a useful proxy for anything else that we care about. We start out, correctly I think, suggesting that what we care about is access and quality. This recommendation doesn't flow from what we know about either of those two propositions. That's troubling and I think it's a different way of describing what was troubling Sheila.

MR. HACKBARTH: Dave, what recommendation would flow?

MR. SMITH: I don't know, and it's the reason I will support this recommendation. But I do think it's an agenda that has got to get higher on our plate, is trying to figure out the rationale, or conclude that there is no rationale, why we so focus on Medicare

margin as a proxy, apparently focus on Medicare margin as a proxy for quality and access even when the quality and access data that we have different doesn't suggest that these two are moving in sync at all.

DR. REISCHAUER: Just a the comment on that, David, and that is that I think the margin information is actually the canary in the coal mine. By the time you get to be able to measure an access problem you are in freefall, I think, and probably the same is true for quality.

MR. MULLER: I totally agree with Bob's summary there because what happens in terms of access and so forth is then people really do know their direct costs versus their total costs and keep services going if it covers direct costs. They don't necessarily reduce those as quickly as a total margin calculation might suggest. And certainly in terms of quality, all the discussion we've had, at least the years I've been on, is how hard it is to measure in the first place. So the notion that if it's hard to measure in the first place you can somehow capture changes in it quite quickly is hard to conclude. So in that sense, since

we're measuring a very difficult area we shouldn't be able to capture differences in a very difficult area that quickly.

We even, as we've discussed with our three-year lag in cost data, we have enough anxiety about that at times as to how one runs that forward from a three-year old base each time. So I think there's good reason, as Bob has suggested, to worry about our ability to capture access and quality very quickly. At the same time I agree with David's point, it's an evolving field. Obviously if one has spent 50 years trying to get cost reports to work, one can't assume that access and data can be nurtured and made mature in a five to 10-year period. I think it's going to take a while -- maybe not 50 years but it's going to take a while to have the quality information that's really only been focused on I'd say in a four to six-year period to be anywhere near the level we want it to be.

DR. WOLTER: The comment that the overall margins are adequate in aggregate I just think over time needs a little clarification, because is 1.8 percent adequate in aggregate? Is 1.5, is 2.0? I don't know

what the right number is and I know we don't have that fleshed out here. But I worry about it because we would then either be targeting to get everybody to 1.8 percent in these subsectors perhaps and feel that that's okay or something else. I'm really not sure what the policy implications of that are because we're obviously concerned that there are institutions within this aggregate 1.8 percent, half of them, who have negative margins that seems to be influencing our decision on the productivity factor this year. So it's just a question that I wonder where we might go with over time.

I'm also concerned as we've had this discussion that pops up through the day that the inpatient margins look, relatively speaking, better than the outpatient margins. I do have some concern that the current outpatient system may not have the right base set point for overall aggregate coverage relative to inpatient. I think the update recommendations here are fine because they're aimed at both, but again, over time are we going to try to have the APC system on average cover the cost of an efficient provider or not? And we may not be able to trust this margin data, outpatient

versus inpatient. But I think at some point we might want to clarify where we want to take that discussion.

Then lastly, in the recent legislation 0.4 percent of the inpatient update is tied to the quality reporting. I think we have been in other sectors trying to create encouragement around linking some payment incentive to quality. This may not be the year to try to do that in the fee-for-service inpatient and outpatient side but I wonder if we should at least have some comments in this section that we do encourage, as time unfolds, looking at mechanisms to link quality reporting and measures to payment.

DR. NEWHOUSE: I want to underscore what Sheila said in that I think the chapter needs to have a statement that we're not abandoning our framework and have some explicit reference to both productivity and S&TA and then basically go on with the response that you, Glenn, gave to Sheila as to a judgment call about what is going to be an adequate pot for 2004. Explicitly margins are in that mix, because that was your first point, and in fact your third point was the distribution of margins. But we wind up saying it's a

judgment call.

On Nick's point, if we're going to say how adequate is the APC, I would prefer, as I said before, that we compare that against the direct cost of the outpatient department on the assumption that, as I said before, that the joint cost will get picked up in the overall Medicare margin in any event.

DR. ROWE: A couple comments about margins. Over the course of several years here I think the most important piece of progress we've made in this has been going to the most-of-Medicare margin as opposed to the inpatient Medicare margin which is what we were focusing on some years ago because of cost allocation issues, and because of adverse incentives to put activities in one place versus another, and because of the evolution of medicine and the importance of outpatient. So I feel while this is maybe not satisfactory it's a lot better than where we were I think from my point of view.

I think some comments about the margin is 1.8 or whatever it is, what does that tell you? What's the difference how low it is, what does it tell us about what we really need to know? If we take that approach I

think we should be disinterested. That is, I think we would have to say that there is no margin that's too high as well as no margin that's too low, and I don't think that's what I here. What I hear is when the margins are high, they're too high. And when the margins are low, it's what does this really tell us? So I think we need to be careful about that.

What it really tells us, whether it's too high or too low is obviously related to what proportion of the revenues of the organism or organization are related to Medicare. So it might be very different at different entities.

I wanted to emphasize that I think the margins are interesting if for no other reason to watch the trend of them over time. Maybe not to make the individual annual decision based on them as we're urged to do when they're low and we're urged to neglect them when they're high. But to look at the trends over time. I thin that does tell you something about what's going on in the sector and I think it tells you something about my favorite hobbyhorse, which is access to capital.

So if we were not going to use them to make any decisions -- it's kind of like a PSA level. Any one number isn't that helpful. You have to have several years of PSA levels before you can tell a patient whether or not his PSA is going in the wrong direction or not. So I do think from a trend point of view they have some intrinsic value although I would agree that we shouldn't overly rely on them.

The other thing I would say lastly is that, in addition to being concerned about the variance, my concern about the variance with this particular group or the new group of losers, these non-teaching hospitals, is that the median number -- and this is a reprise of some earlier conversations -- the median margin number is moved to the left front rather than to the right. I wouldn't be so concerned if the variance was still great but it had moved to the right, other than maybe we need to reduce payments. But if it's moved to the left and there's still variability, then I think that's the instance in which we should put a microscope on the lower end and really analyze it to see if there is some intrinsic deficit in the way we're treating them.

MR. HACKBARTH: I think that's an excellent point. Allen Feezor, Alan Nelson, and Ralph and then we need to move on to the outpatient presentation.

MR. FEEZOR: I was going to reinforce Joe's comment about we do need to make explicit the retention of our policy with respect to productivity and the like. Then Jack took my other comment about that we need to -- I think it is incumbent upon us to begin to try to establish correlation between margin and access. That's access both to care and to capital and I think begin to monitor that more, or look at that more in that perspective.

Then the final thing I guess, in this next round of applications for clinical access hospitals I would like, if we could, to track the concentration or the growth in concentration of for-profit hospitals in that particular sector.

DR. NELSON: I'm uncomfortable with our apparent inconsistency here. Elsewhere in our report we're going to explain and justify why we believe productivity should be applied to these other segments. So I'm uncomfortable then with us plugging in

productivity one year and not another year based on what the circumstances are. It seem to me we ought to try and have a uniform approach that we apply as broadly as we can and as consistently from year to year, and we do. The first question we say, are payments adequate currently, or are Medicare payments in 2004 adequate?

If indeed we undershot and margins are lower than they are because we miscalculated on what the costs were going to be then we ought to say, and we ought to have a 1 percent get-well factor. We ought to say it's because we undershot. Then we ought to go ahead and apply a carefully calculated market basket with productivity as we do for the other Medicare portions. I'd be much more comfortable with that rather than for us to just sort of fudge it.

MR. MULLER: Alan has expressed what I feel as well because we have the framework of payment adequacy plus update in a variety of areas today and in other years when we have margins of 10, 12, 15 percent in SNFs, et cetera, and so forth we say, payments adequate and we probably don't need an update and we vote not to give updates. In an area here where there's, I think

some could argue that 1.8 is not adequate we've, in a sense, taken the -- as Alan has said, we've basically taken the productivity and used that as a way of dealing with the adequacy issue. In other words, instead of saying, let's make them adequate and then you can do the update minus productivity.

Now I agree with the recommendation that was made. In a sense we've kind of backed our way into it. But in terms of the framework that we have, if we're going to maintain that kind of adequacy plus update framework then at some point we need to say when are margins inadequate? In a sense, the DIMA has done that with a bunch of add-ons in the specific areas that you talked to earlier, the rurals and making more critical access hospitals and so forth. That's another way of saying that the payments there were inadequate and therefore they'll get more than updates because -- I can't remember now what the increases were, Jack. It was 6, 7 percent whatever came in DIMA, for the rurals. It's probably more than 6 or 7 percent. In a sense they had a -- that was an explicit judgment about adequacy that was not there and therefore they would get more

than the update.

The way I understood your comments earlier, that rather than overall updates you would at least like to have questions of adequacy subdivided into areas where they need to be fixed, whether it's rurals or critical access or whatever. But if we're going to maintain the adequacy argument and especially not do updates on the ones that are plus 15, then I think we also, when we're below some threshold of adequacy -- and I'm not sure we as a commission have decided what that is, but 1.8 I could argue pretty clearly in my mind is below an adequate level. That being said, I agree with the recommendation but I think we should consider about how we maintain our consistency there.

DR. REISCHAUER: I think Alan stated it nicely. We're going to end up at the same point for all practical purposes but we should stick with the procedure and framework that we had layed out. That makes the case for how we'll deal with this issue next year a lot clearer to the world as well as justifying what we're doing this year in a more coherent way that hangs together with all of our other recommendations.

MR. HACKBARTH: It requires an explicit finding that 1.8 percent is inadequate. Is it the 1.8 that's inadequate or is it the number of losers that are inadequate? Is it how far the losers are from 1.8 that's inadequate?

DR. REISCHAUER: All of this is a judgment, and the general feeling of discomfort which leads us to believe that there should be a boost of something like 1 percent and then moving forward, market basket minus productivity plus S&TA.

MR. HACKBARTH: Other reactions to that proposal?

MR. SMITH: For reasons of consistency and clarity I think Alan's proposal makes awfully good sense. It does get us closer, Alan. I don't know whether it's a negative implication or not. I know it's an implication we will be asked subsequently to wrestle with is, okay, you have implicitly stated that 1.8 is too low? What about 3.8 or 15.4? We are sliding -- Bob, you're right it is a judgment call and we ought to make it.

DR. REISCHAUER: It has a lot of different

dimensions and we don't want to give particular weight to one or the other.

MR. SMITH: But we are. We have in this conversation and we will in the text. I think Glenn said it clearly. What has troubled us to the point of declaring inadequacy is not any capital market data, it's not any access data, it's not any patient discharge data. It's a 1.8 average margin. That is what has rung our bell, or killed our canary.

MS. RAPHAEL: I think Jack made a good point, which is we need to look at the trends here and not just one year.

MR. HACKBARTH: Julian?

MR. PETTENGILL: On the other side of that, a couple of things. One is, the recommendation is for one year only. Next year you get to revisit it again. And when you ask the question about whether current payments are adequate next year you will be in effect revisiting the question of whether you overshot or undershot this year. So that's one way in which the level of uncertainty that you should be carrying around here is perhaps smaller than the margin level would drive you

to.

The second thing is, as David pointed out, the margin is only one factor here. You have the other indicators and they're not showing problems.

In addition to that, the margin distributions that you look at for Medicare are extraordinarily wide. I think we've said this to you before and we've shown you data, and we can do it again, we would probably should do it again, any group you can define, I don't care what it is, has a very wide distribution of margins.

So what exactly does that mean? When you put that together with what total margins look like we've shown you also that there's no relationship between Medicare margins and total margins.

So it hospitals' behavior is driven by what their overall financial condition is rather than by what is going on precisely with Medicare, should you react strongly to a 1.8 margin in one year? I don't know. I think there's a level of uncertainty here that you should reach to, but don't over-react.

MS. RAPHAEL: You have sectors here like

nursing homes and home health that have very small total margins but high Medicare margins. Here you're saying we have the reverse, we have higher total margins and lower Medicare margins. So what does that lead you to do in terms of a consistent stance?

MR. PETTENGILL: For hospitals what you have is no relationship between Medicare margins and total margins.

MR. MULLER: Some of this goes back to the DSH discussion of prior years where one of the reasons you have this inverse relationship between Medicare and total is that hospitals that had high Medicaid had lower total margins. By having an DSH payment as a matter of policy it drives up your Medicare margin. So in a sense, a policy judgment has been made to drive up the Medicare margin because you have a low total margin because you have Medicaid.

So I would say there's a real policy reason for that inverse relationship by and large because the reason you have low total margins is high Medicaid and high uninsured. So I don't agree with your hypothesis at all. I think there's a real policy reason for that

relationship that has been well-established for however long DSH has been around.

DR. MILLER: Fundamentally I think what we're asking here is whether we're making a conclusion that it's inadequate now and applying the framework or whatever the case may be and then making a recommendation, or whether we look at this and make this judgment a year from now. Part of what we're talking about here -- the legislation passed a month ago and there's a lot of activity about to happen and starting to happen now and this is our best shot at modeling the impacts of it. But there's a lot of uncertainty that exists just in that.

MR. MULLER: But you're showing 1.7 for 2002. I think Carol and others have made the point, several people have made the point there's been a trend here that's going on for a while that has been going down, costs have gone up for the reasons well-articulated inside the chapter. So I don't think anybody is just saying there's a point estimate that has hit us today and we're saying, eureka, we never knew this. We've been watching these trends for quite a while and whether

one uses Bob's metaphor of the canary in the mine, there seems to be evidence accumulating over the years that costs went up more in this field, and they may go up in other fields as well.

As I argued in response to Julian, I think there's a reason why Medicare and total margins can be, if not totally inversely related at least highly negatively correlated, and that's a policy that has brought us to that in part. So I think it's a cumulation of evidence, not a single point estimate. And I think whether it's in terms of Sheila's initial admonition to us that we should put this into context rather than just saying, there's a point estimate here that has taken us over the line. It's a cumulative discussion, cumulative evidence that has caused us to say, this one is too low, and that's what I liked Alan's formulation of it. But I think it's not just one thing.

Also if we're sitting here a year from now and the estimate for 2003 is also at the 1.7 level and so forth -- I agree with you, it's hard -- to necessary to forecast '04, '05, but '02 we're showing here is at 1.7, which is a marked decrease from the 4.1 and 5.1 that

we're showing for the two prior years.

DR. ROWE: I think it's important to take both sides of each of these arguments just like I suggested if there's no margin that's too low there shouldn't be any that's too high. As Julian says, you don't have to make a change because it's only an annual adjustment and if you missed it you can make it next year. If we made it and it was more than we need to, we can compensate next year in the same way. So that doesn't persuade me in one direction or the other.

I think I'm concerned about what Bob said about the latency here, that by the time you see effects in some of these dependent variables that we pointed out we haven't seen, it may be too late. Things crash and then it takes a while to come out.

I remember discussions with the administration after the so-called Balanced Budget Act of '97, two years into the academic medical centers were screaming and the administration was saying, we don't really see evidence that you've having -- this isn't changed, that hasn't changed. Why don't we wait? It's a little hasty to put money back in. We think it's going to be okay.

Then by the time things got around to getting corrected a little bit there were a number of institutions that were very severely affected.

So I think our goal is to have as smooth a curve as possible. We don't want crashes and then peaks of big margins and then crashes and peaks. That's the problem with federal policy in these area. Don't we want as smooth a curve as possible? Isn't it likely that by throwing a little more on the table here we're more likely to have a smoother curve than a spiked curve? That's my sense of what I'm hearing and what I'm seeing in the numbers.

MR. HACKBARTH: But what I hear is a consensus about the dollar amount, and the only issue is whether we characterize it as a step one adjustment, the payment adequacy adjustment, or whether we do it in step two and change the proposed increase for the following year. I think the conversation has well-captured the logic and benefits of the two approaches.

It is a change though and I'm the sort who gets nervous about making changes like this without thinking them through. What I'd like to do is just

think through this some more tonight and what the potential implications of the two approaches are before we go one way or the other.

MS. BURKE: Glenn, I unfortunately can't be here tomorrow so let me just leave one further though as you think about this for tomorrow. As you look at what the possible implications would be I would give careful consideration as to whether it will have any impact on the spending implications against budget. If there's any structure that will change that I would have great concern because I think it will meet opposition if it's outside of what is anticipated, would be my guess. I don't know that it would, but depending on how you construct it and how it's characterized as either market basket or some variation that is above that, I would just worry if all of a sudden we have a budget hit that we have to explain.

DR. ROWE: We voted on a couple things earlier today that had budget reductions.

MS. BURKE: I understand that. In each of these I'm cautious about -- I mean, we will be where we are but I want to go in knowing what that is because

there will be some impact.

MS. RAPHAEL: That just raises the issue of that 0.4 reduction if you don't produce the quality report, which is in current law. Nick raised the issue of if we want to say anything on that, given that we are trying to move ahead on the quality front in every sector here.

DR. WOLTER: I was just going to comment on that again, Glenn. If we end up with whatever the approach is at a certain number and don't comment at all on the quality tie, could that be interpreted by some as we're recommending that that be moved away from? We just might want to think about whether or not we should comment.

DR. NEWHOUSE: I think we should comment. I think that's a good point. And I also think that we ought to say that in our judgment about the update factors we will ignore the effects on margins caused by non-compliance with that provision. I think in practice that's going to be, again, a judgment call, but I think the general principle is that we want the hospitals to comply with this and we're not going to, in effect,

float everybody up if people don't -- to the degree people don't comply.

MR. HACKBARTH: My personal feeling is that I wouldn't want a failure to address it to be interpreted as a lack of support for the principle that the data ought to be provided and we think that's the direction to move. I do have reservations about the approach of paying differential for the provision of the data.

My own view of this is the data are important and they ought to be provided as a condition of participation in the program and we ought not have differential updates based on whether people provide data. I'm worried about the precedent that that establishes. We have a whole lot of other people with data issues and concern about the cost, but I absolutely agree, Nick, that we should not allow silence to be construed as a lack of support for getting these data. I think they're critically important.

DR. REISCHAUER: We don't think you should be able to buy your way out of providing information that's critical to maintaining and improving quality.

MR. HACKBARTH: Right. Let's turn to the

outpatient piece. Chantal.

DR. WORZALA: Good afternoon. We'll be making an update recommendation for calendar year 2005, and under current law the update should be market basket. The outpatient PPS update itself was not affected by DIMA. However, there are provisions in that law addressing payment for drugs under the outpatient PPS and also extending the hold harmless policy for certain policies. Both of those are expected to lead to higher payments than previous law.

To put your decision in context, the Office of the Actuary estimates spending under the outpatient PPS to be $21.6 billion in 2003 and about 38 percent of the payments coming from beneficiaries. As you know, we do conduct our assessment of payment adequacy for the hospital was a whole and have been talking about that up to now. Just as a point of information I'll provide you with the outpatient margins before moving on to the update.

The top line of this chart shows the overall Medicare margin, again, our principal measure of hospital financial performance because it addresses all

of the service lines that hospitals provide and obviates some of the cost allocation problems. As Julian discussed we also consider a host of market factors. As Jack pointed out, the 2004 estimated overall Medicare margin is 1.8. That does include the outpatient PPS provisions in DIMA that I had mentioned previously.

You can see the trend in the outpatient margins here and you may recall that we had slightly different numbers presented at the December meeting. As Jack alluded to, we did identify a data error in the cost reports and it turned out there was a subset of hospitals that did not have full outpatient charges reflected in their cost reports. We understand from CMS that this was an error stemming from difficulties some FIs experienced in processing claims and generating the PS&R reports. The PS&R report is the source of charges for the cost reports. Due to the omission of these charges we did overestimate the outpatient margins for 2002 in December. The final estimates presented here use imputed values for the hospitals identified as most likely to have had missing charges on their cost reports in either 2001 or 2002.

So what are the numbers? There was substantial improvement in the outpatient margins from 2000 to 2001 in the aggregate moving from negative 12.2 to negative 6, and this does coincide with implementation of the outpatient PPS. The kinds of factors that would lead to the improvements in the margins are the transitional corridor payments which were designed to temporarily add money to the system. We did have pass-through payments that were exceeding their budgeted cap in 2001. We also see from our own analysis that outlier payments exceeded their cap in 2001.

In addition, hospitals may have been sensitive to controlling costs, particularly outpatient costs, in this period in response to the uncertainty of a new payment system coming online.

As you can see, the margins then declined between 2001 and 2002 moving from negative 6 overall to negative 8.2. Again several factors explain the decline, most obviously the cost growth that we've been discussing which, of course, would cut across service lines I think. We had lower transitional corridor

payments in 2002 by design and the pass-through payments were subject to a pro rata reduction in 2002, and we saw outlier payments more in line with their cap in that year as well.

In thinking about how payments might changer after 2002 there were two provisions in DIMA adding new money, the change to the drug payment where we're making separate payments for more drugs with some floors on the payment rates. Then we also have the extension of the hold harmless policy. There is one possibility that would lead to a decrease in payments and that's the end of the transitional corridors for all but those hospitals held harmless.

As Julian noted we do have some uncertainty as we move into our decision-making process and we do have evidence that cost pressures are easing, but we do not know exactly how quickly. There are some issues on the payment side as well. Consequently, we propose making the same recommendation for the outpatient PPS as the inpatient, and that would be that the Congress should increase payments for the outpatient PPS by the increase in the hospital market basket for calendar year 2005.

This recommendation is the same as current law and we anticipate no implications for beneficiaries or providers.

MR. HACKBARTH: Questions, comments?

DR. NEWHOUSE: We could clearly have a reprise of the prior conversation which I don't think we want to do but I think in terms of writing -- assuming that we're going to support the recommendation, that we again come back to our judgment about the overall pot of money since most hospitals have an outpatient department and we think it's money going to the total hospital then that's rather -- I think rather than -- we're not proposing to arbitrarily divide it up in some way between more in the inpatient and less in the outpatient or vice versa. That doesn't get to Nick's concern but I'll have a side conversation with him about how we update.

The other thing I just wanted as a small point, I assume our projected or estimates consider the -- let me ask it this way. What's the impact of the extension of hold harmless and new drug provisions on this on the outpatient side?

DR. WORZALA: Let me just get to that page again. I do have the numbers. This is from our estimates and the drug and the hold harmless provisions result in a margin that's 2/10 of a percentage point greater than the decrease from the transitional corridors. So the net of losing the transitional corridors and having these new BIPA provisions is a positive 0.2 percent on payments.

MR. HACKBARTH: Joe, on your first comment I'm not sure what you were saying. Were you saying that --

DR. NEWHOUSE: We should reiterate that we're holding with our framework that productivity -- but actually here not S&TA -- S&TA applies but that we're still uncomfortable with the overall pot of money at the hospital as an entity, and our judgment is that the hospitals need more money and we're giving them more money in part through the inpatient and in part through the outpatient update.

MR. HACKBARTH: So if we were to adopt Alan's proposal for a step one adjustment would we characterize both as a step one?

DR. NEWHOUSE: I actually didn't frame it for

myself the way you framed it, was it step one or step two. It could in principle be either. I was going to go home and thing about. But so in response to you is, whatever the answer to that question is I would make it for inpatient and outpatient.

DR. ROWE: I think to whatever extent we're better off with overall Medicare margin as a better reflection, for the reasons we talked about earlier about the shift from one site to another site of health care and the changes in technology and your ability to move patients around and reallocate costs and all that we don't want to -- if any adjustment is made, make it just in one of these two pieces. That would be a mistake. That would provide incentives for what we're trying to get away from. So to whatever adjustment gets made I would then parse it across to two areas in such a way as it's neutral and it's not going to result in behaviors which we're trying to get away from.

DR. NEWHOUSE: The real implication of that, assuming we are adhering to our framework, is the difference with the S&TA and whether that does create a small difference in how we treat these. But maybe we

can take that up tomorrow.

MR. SMITH: I think the elegance of Alan's argument about consistency does argue for doing this as a step one adjustment and holding on to the productivity modification of the market basket update. We could do it in a single step. We could say we believe that because of the low overall margins this is a year in which we ought to forego the productivity target, but I think it's probably better to do it in two steps, although at 0.9 and 0.9, Alan, not one and 0.9, so we don't inadvertently step on the problem Sheila raised.

MR. HACKBARTH: Any other comments about outpatient?

Okay, as I said we'll take this up and do our votes tomorrow morning on both the inpatient and outpatient. So I think we're done for now and we'll have a brief public comment period.

MS. COYLE: I'm sorry, if I could, just 30 seconds. I was trying to get around and back in your standing-room only audience. Carmela Coyle, from the American Hospital Association.

I really wanted to offer two thoughts for the

Commission's future consideration, but given that the votes didn't occur today I now have to throw in just a little note up front. That is as we take a look at both the hospital inpatient and outpatient data that's just been presented, costs are up, hospitals' financial performance is down, the performance trend is on the decline, and as staff has just suggested to you, 50 percent of hospitals have negative Medicare margins. So we would strongly encourage this commission to vote for full updates on both the inpatient and the outpatient side tomorrow.

But two thoughts for the Commission for their future consideration. Number one, we would strongly encourage the Commission to again revisit the update framework, especially as it relates to the application of the productivity targets that have just been the object of conversation this afternoon. Number one, a suggestion that you discuss and revisit the premise of a productivity target. And number two, specifically the estimation of that target. Clearly it's an important issue. It's important beyond the hospital setting, in the home health SNF setting. And given the conversation

today would strongly encourage that you do that.

Second, I guess listening from the perspective of the audience I think the discussion this afternoon really illustrated the variation in performance, and you talked a lot about that, under these various prospective payment systems, and the difficulty that that presents in assessing payment adequacy. May just respectfully suggest that perhaps some of these issues really lead to the question of whether this prospective payment systems are really functioning adequately. And a thought and would offer some help, we as the American Hospital Association have actually convened a group of what we hope are some thoughtful people to carve out time -- and I know that's the hardest part of your jobs here -- but to carve out some time and to really begin taking a look at might there be some new payment approaches, some new payment systems where the focus is the provision of efficient care?

I don't know -- I know this is an incredibly busy commission. You've got lots of reports that really drive your agenda -- whether that may be an opportunity for a future retreat discussion, if not this year

perhaps into the future. But again, just listening, some of what you've talked about here illustrates maybe these systems after at least 20 years on the inpatient side may not be serving us as effectively and adequately as could be. So would just offer that up for your consideration. Thank you.

MR. HACKBARTH: Okay, we're adjourned and we reconvene at 9:00 a.m. Thank you.

[Whereupon, at 4:59 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Thursday, January 15, 2004.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, January 15, 2004

9:15 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
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.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Good morning.

I'm sorry for the delay. Let me quickly review what we're going to do this morning. The first thing we're going to take up this morning is a piece of business left over from yesterday, which is to vote on the hospital recommendations for inpatient and outpatient, and that's the reason for the delay right now. I want to make sure we've got all the commissioners here for that vote.

Once we finish that, we will then turn to the published agenda, which includes outpatient PPS, outlier policy, ambulatory surgical centers, long-term care hospitals research agenda, and dual eligible beneficiaries, some analytic work that's going on there.

So we are going to wait to get the couple commissioners I know are here in the building in the room for the vote.

Rather than sit here waiting for people, what I'm going to do is let's do the outpatient PPS outlier discussion and then right after that we will turn to the hospital vote. It just doesn't make sense to waste time

sitting here waiting for people to come in.

DR. WORZALA: Good morning. I'm here to talk about the outlier policy for the outpatient PPS. Of course, we've discussed this policy in the last couple of meetings, so I don't want to cover any of the background of a conceptual basis or how it actually works. I'll just focus on the policy question at hand, which is does the outpatient PPS need an outlier policy?

As we've discussed, there are several conceptual reasons you might want an outlier policy in the outpatient PPS. First, there has been a shift toward more sophisticated and more costly services moving to the outpatient setting, although it is still predominately a low pay, low cost set of services.

Second, the outpatient PPS is a fairly new payment system and it's been difficult for CMS to set payment rates, given the data available to the Agency. And in that context, the outlier could provide a cushion for rates that are too low. The best strategy would, of course, be to fix the payment rates. But in the interim, we could use the outlier to make up for inaccurate rates.

Third, the distribution of cases may not be random across hospitals. So if some hospitals routinely provide services to more costly patients, the outlier would help to compensate them for that risk. Again, it would be better to have a payment system that adequately addressed that in the first place.

The evidence, however, suggests that the arguments against having an outline are stronger. We've discussed them in the past. Here I've grouped them into conceptual arguments, findings from my data analysis, and policy considerations.

First, many outpatient services have a narrow product definition and includes many ancillary services and inputs, such as a drug, that are paid separately. This would suggest that the variability in costs across individual cases will not be great.

Second, the APCs generally have low payment rates. This means that the size of the potential loss to hospitals from having a relatively costly case is generally small.

When we look at the data, we find that most of the outlier payments have been made for services with

low payment rates, suggesting that as its operating currently the outlier policy is not covering large financial risks to hospitals. We also find that the payments are not evenly distributed across hospitals and this becomes an equity issue, given that outlier payments are funded through a decrease in the conversion factor.

Then from a policy perspective there are additional arguments. First, there is a potential for outlier payments to be made in response to increases in charges and not necessarily increases in costs. And this is due to the way the outliers are calculated, as we've discussed. Relies on outdated cost to charge ratios and we have seen that there's been a decline in the ratio of cost to charges, suggesting that charges are rising faster than costs.

Second, administering the outlier and protecting against gaming are administratively costly and must compete against other priorities for both staff and monetary resources on the part of the Agency and fiscal intermediaries.

Finally, the outpatient PPS is the only

ambulatory setting with an outlier policy. However, many of the services provided can also be provided in physicians' offices or ASCs, and so having an outlier policy in one setting and not the other creates one more difference in how the services are paid across settings.

Last month I presented you with the distribution of outlier payments by service in 2001. Now I bring you more recent data. All of my 2002 results come from an analysis of a claims file that spans the period April through December of 2002 and includes 100 percent of the outpatient claims.

In 2002, as in 2001, a relatively small number of APCs, 21, accounted for 50 percent of the outlier payments. These same services accounted for only 36 percent of the APC payments. Among those 21 services, only one, a cataract surgery, had a payment rate over $400.

This slide shows some of the specific services that accounted for a large share of the outlier payments in 2002. The order of services did change between 2001 and 2002 but very similar services appeared in both years. For example, x-rays ranked third in 2001 but are

first in 2002. Electrocardiograms ranked fifth in both years. These eight services accounted for 29 percent of the outlier payments but only 17 percent of the APC payments. Again, payment rates are low.

This table groups the services by their payment rate and shows what share of outlier and APC payments went to the services in each payment band. You can see that services with payment rates of less than $50 accounted for 24 percent of the outlier payments but only 11 percent of the base APC payments. Altogether 75 percent of outlier payments went for services costing $300 or cost and these services accounted for about 54 percent of the base APC payments.

For the most expensive services, those with payment rates above $1000, the share of outlier payments is only 7.6 percent, even though these services accounted for 26 percent of the base APC payments. Thus, the higher paid and presumably more complex services are not accounting for even a proportionate share of the outlier payments.

In the last presentation, and in your briefing papers, we looked at the distribution of outlier

payments by hospital group and noted that hospitals in large urban areas, teaching hospitals, and for-profit hospitals got larger shares of the outlier payments than they did of base APC payments. These hospital groups also received a greater share of their total payments through the outlier mechanism. Those patterns held in both 2001 and 2002.

This table looks at distribution across individual hospitals and tries to speak to the equity issue. The bottom line message is that most hospitals receive very few outlier payments while a few hospitals received a large share. Recall that the base payments for all hospitals are reduced to finance the outliers.

We have segmented the hospitals according to the share of all payments coming through the outlier policy so you can see that at the bottom of the distribution 10 percent of the hospitals receive less than 1/10th of 1 percent of their total payments in the form of outliers. These hospitals hardly received any of the outlier polices as a group, 1/10th of 1 percent. In contrast, at the top of the distribution, 10 percent of the hospitals received 4.8 percent or more of their

payments through the outlier mechanism. As a group -- yes.

MR. DeBUSK: Let me ask you something. You're looking at the percentages of hospitals. What about the number of beds?

DR. WORZALA: Well, this is an outpatient.

MR. DeBUSK: It could still be capacity.

DR. WORZALA: Right. I don't have that information. I could try and get it for you.

MR. DeBUSK: So the number of hospitals may be insignificant on that basis.

DR. ROWE: [off microphone.] These are the larger outpatient facilities seeing give times as many, 10 times as many patients.

MR. DeBUSK: Right, that's the point.

DR. WORZALA: That's true, this isn't weighted by revenue, for example.

DR. ROWE: [off microphone.] Outliers as a percent of patients or as a percent of plans.

DR. WORZALA: It's outliers as a percent of payment. I'm not looking at the straight outlier -- it's not the 1 percent of hospitals that got the most

outlier payments. It's looking at outliers as a share of their total payments.

DR. WOLTER: One other question I had on this was would it be a fair inference that say in that top 10 percent that are getting 35 percent of the outlier payments, that the majority of those payments are in the lower-priced procedures?

DR. WORZALA: Yes.

DR. WOLTER: That would be a fair inference, just based on the other?

DR. WORZALA: I think that's a fair inference.

So you have 10 percent getting 1/10 of 1 percent of the outliers and top 10 percent getting 35 percent of the outliers.

I should note that moving forward after 2003, when CMS started to use more current but still at least one year lagged cost reports to calculate the CCRs, you may see that top band sort of moving back because there will be less opportunity for gaming. But still it will still exist.

So we saw from our hospital group analysis that teaching hospitals have a greater reliance on the

outlier payments than other groups. The major teaching hospitals in 2002 received 2.4 percent of their payments as outliers compared to 1.7 percent for all. And I should note 1.6 percent for other teaching hospitals.

Since teaching hospitals do have a mission that includes treating sicker patients and promoting innovative products we might want to look more closely at their outlier payments.

So what we did was to repeat the previous analyses for the sub-group of teaching hospitals and we did find that they had a similar distribution of outlier payments by service as all hospitals did. X-rays accounted for the greatest share of outlier payments to teaching hospitals, about 4 percent. Similarly, services with low payment rates, $50 or less, accounted for 24 percent of the outlier payments. The services with the highest payment rates, those over $1000, did not account for a large share of the outlier payments received by teaching hospitals, 8 percent.

We also looked at the distribution of outlier payments among teaching hospitals and found a similar level of variation as we did for all hospitals. The

bottom half of teaching hospitals received 16 percent of the outlier payments while the top 10 percent received 42 percent.

After considering the data and arguments presented above we propose the following draft recommendation. The Congress should eliminate the outlier provision of the outpatient prospective payment system. This has no spending implications because the outlier policy is budget neutral and the funds would simply be returned to the conversion factor.

The policy should have no material impact on beneficiaries; access to care, given that the policy doesn't seem to be covering large financial risk. Hospitals that had been receiving large shares of the outlier payments may have lower revenues. Other hospitals will receive greater base payments when the outlier funds are returned to the conversion factor.

DR. REISCHAUER: Just in how we characterize the budgetary impact on this, ideally it should have no budget impact but historically it would have because while it's supposed to be budget neutral, it never has been.

DR. WORZALA: Could we score that as a savings or something we put in the text?

DR. REISCHAUER: You know, taking off my CBO hat, no, but I think we should mention it. As implemented, this policy has cost money and is likely to in the future.

MR. FEEZOR: Chantal, it's a thorough analysis and I compliment you on that.

I got the feeling as I started reading it that somehow differently from other chapters that we've done where we've made major recommendations, we sort of started with our mind made up. And I don't know that the analysis and the process that we got there, but it just sort of the way it was worded or my conclusions.

So I think we do a thorough analysis of sort of the financial redistributional and the hedging impact of the outlier policy, in this case. But if you look back at sort of the public policy objectives, one was sort of the hedging or the financial aspect. The other was the access issue.

I don't think we do as good a job and I think we need to spend a little bit more time of either

assuring policymakers, including ourselves, that yes, that will or will not in fact impact access for the fragile or the complex on the outpatient basis.

Your last slide, when you talked about sort of the correlation, one would assume between university or teaching hospitals and their patient mix, maybe you can make some deductions. But I think we need to make a much stronger case, that we start out in the first part of our chapter here, saying the other reason is to make sure that there would not be a disincentive for hospitals to, in fact, treat the complex and high risk case.

I just don't think we've made as strong a case here as we need to, whether it's anecdotally, whether there are some studies or a little further correlation between where those patients go in the patient mix would be helpful.

DR. ROWE: Can I ask Bob a question about the budget observation? If the implementation of the outlier policy resulted in increase in expenses, let's say from X to X plus Y, if we get rid of the outlier policy does that mean that the total amount of money

that's going to be distributed across hospitals is X plus Y? Or do you think it would go back to X? In which case it would actually be a savings by getting rid of the so-called budget neutral outlier policy?

DR. REISCHAUER: It would go back to X, because what happens now is the Secretary says I expect outlier payments to be 2 percent of the total, sets the parameters so as to meet that total. It turns out to be 3 and the trust fund or the S&I trust fund eats 1 percent and we never go back.

DR. ROWE: Thank you, because I was thinking that an alternative that somebody might say is okay, you want it to be budget neutral. We'll take the amount that was spent last year and we'll distribute it across the hospitals, which was therefore budget neutral. But that has already embedded in it the Y component, which was the increase associated with the implementation of the outlier policy.

DR. REISCHAUER: The question on scoring is whether CBO, when projecting forward Medicare spending, assumes that the Secretary is going to be wrong in the future, a bias in there. It probably does.

I want to just build on the last comment, and that is I think you're right, that we have to explain very carefully the other side of this argument. But I'm not at all convinced -- you know, we do our breaks all the time, teaching, urban, rural, whatever, big, small. And it's not clear to me that necessarily there's sort of a behavioral element to his that these might be categorizations that are highly correlated with something else.

If the outliers were predominantly for complex, expensive kinds of things, I'd have a little more sympathy for this. But when we're talking about an x-ray, there's something else going on here. And I'd want to see a multivariate analysis, one variable of which was change in your cost-to-charge ratios.

It could be that teaching hospitals are cruising down this curve at a faster rate that the average, as are for-profit hospitals and things like that. And then, when you threw in a teaching/non-teaching variable it would be insignificant. But we could go through this and think exactly what it is that we think produces this kind of behavior. And in the

best of all possible worlds, it would be teaching because the teaching would have more complex cases and more variability in those cases and all of that. But when we look at this aggregate data, it doesn't look like that's the case.

Or we could look at the amount that the teaching hospitals get and find that that's where all the complex, the outliers for complex procedures are and in the other hospitals it's all for x-rays.

DR. ROWE: But there is a difference in the teaching hospitals between the major teaching and the other teaching. There's a big difference. So while Chantal said in her slide shows that the distribution of outlier payments seems to be same in teaching hospitals as in the non-teaching, in the major teaching there's this huge difference between major and other teaching. That might be consistent with the argument you're saying about those because those are the kinds of procedures are concentrated --

DR. REISCHAUER: About those or about variability of cost-to-charge ratios within subgroups of categories of services is greater in those hospitals.

Who knows?

DR. ROWE: When you back to not having an outlier policy and there's this budget neutral effect, are the funds distributed within categories of hospitals? That is, the funds that went to teaching hospitals go to teaching hospitals? Or is across all hospitals?

MS. DePARLE: It's back into the regular APCs. So whatever is spent, that's what's spent. But I would assume that the actuaries at least, in projecting the amount for the next year, would start from a base that included however much the payments were in the outpatient prospective payment system the previous year, which would include in new technology add-ons and the outliers and everything. What you think, Mark?

DR. MILLER: Chantal, we've talked about this. I'm hoping Chantal answers the question, which is why I didn't turn the microphone on.

I thought when we talked about this, if I recall the conversation, you were saying that the piece above the outlier amount was taken out of the base payment for the purposes of determining budget

neutrality.

DR. WORZALA: That depends on which process you're about. That refers to recalibrating the relative weights. So any sort of spillover payments that happen are not counted for the purpose of recalibrating the relative weights. But when anybody accounts for the spending, all payments are included.

DR. MILLER: So when you publish in the regulation the next year the base payment amount, which is a product of whatever the previous was plus the market basket, the additional outlier payments are still in there and inflated forward?

MR. WINTER: When OAC or CBO has their series of what spending has been, obviously all of these payments are included. But when you set the conversion factor, you are not including payments that went above and beyond what you had planned.

DR. MILLER: So in 10 seconds or less, for purposes of the baseline, it sounds like it's in there. But for the purposes of setting the payment rate, it's backed out before it's inflated forward?

DR. WORZALA: That's correct.

DR. MILLER: Nancy Ann, does that get to your question?

MS. DePARLE: Yes.

DR. WORZALA: Can I just make one comment on the access issue? Conceptually, for their to be an impact on beneficiary access to care, hospitals have to feel that this individual patient about to come through my door will cost me a whole lot of extra money, enough so that I'm going to find a way not to treat this person.

And if they're going to cost you a little bit more on an x-ray, would a hospital do that? I mean, I'm sure there's what it can be done. And that's very crude, that's very conceptual and cold and calculating, but that's sort of what you're saying in order for there to be an impact on access I think.

DR. REISCHAUER: And a lot of these things are a component of a larger service bundle, so you might, in your formulation, lose on the x-ray but pickup on the implanting the defibrillator.

DR. ROWE: I don't think that's how the hospitals think. Or some of them.

DR. WORZALA: I don't think so. That's just what would have to happen in order for the access problem to be there.

DR. ROWE: I'll tell you what I do think may happen and that is that services that were available in some hospitals on an outpatient basis will no longer be available on an outpatient basis and will only be available on an inpatient basis.

MS. DePARLE: That's what people said when we did the outpatient PPS.

DR. ROWE: Yes. And if you look at the major teaching, which get a disproportionate piece of this, they may decide that they want to no longer offer this in an outpatient, just do it inpatient. Which is fine. I don't think that's an access problem for a Medicare beneficiary. But I think that might on the margin, particularly if there's a whole set of these kinds of services offered that require certain infrastructure.

DR. WORZALA: But that would be a systematic payment issue not a random costly individual case kind of argument.

MR. DeBUSK: Chantal, Glen, is this system

working now the way it is? Is it broke?

MR. HACKBARTH: The outlier piece, yes, that's the gist of the recommendation, that it is broke.

MR. DeBUSK: I look back at this outlier piece and it's activity based. And allocating of overhead, as we talked about yesterday in the hospital setting, that's not working. I'm a little reluctant to tear something down here or make this recommendation or vote on it if we're going away from an activity-based system where under that system the cost is allocated where it needs to be.

It looks to me like we're word going in the opposite direction. We're doing more bundling. Maybe we should in this particular instance but theoretically it doesn't look to me like we're moving in the right direction.

MR. HACKBARTH: I'm not sure, Pete, that I'm following. The gist of what we're recommending is that this is broken because it's putting a lot of outlier additional payments focused on services with very small bundles and low unit prices and that's not consistent with the basic concept of an outlier system. It's not

getting the money to the right place. We'd be better off putting the money in the base rate as opposed to having this distribution that this system is producing.

MR. DeBUSK: Maybe so.

DR. NELSON: Help me understand how the charges are established. The charge-to-cost ratio adjustment, I understand that. But if an institution decides to charge $90 for an x-ray, do they charge $90 for just some x-rays or do they charge $90 for all of their x-rays? And if so, how do they determine which ones to charge $90 for and which ones to charge only a normal fee, usual fee?

DR. WORZALA: As I understand it, the law prohibits a hospital that sees Medicare patients from charting Medicare patients a different amount than other patients, so the charges would be equal across all patients.

DR. NELSON: So if I can pursue it, so the outlier charges are established by the facility because that's what they charge all of their patients?

DR. REISCHAUER: But nobody pays charges. A few Saudi Arabians fly in and pay charges but CareFirst

and Aetna and those people aren't paying charges.

DR. NELSON: I guess I don't understand the rationale for this being utilized for relatively low-cost services as duh. I guess what I'm saying is why doesn't the whole world do that if it is, as it appears, a potential license to steal? What is the restriction? Why is it only such a low percentage? Help me understand.

DR. WORZALA: I believe, and please help me those of you who run private insurance companies, I don't know that any other purchaser would have any kind of outlier or -- I'm not getting the word in my head -- but any kind of additional payment for low-cost services. They will have a stop-loss provision but it's $100,000 or something like that. So none of this kind of outlier additional payment would accrue to any outpatient service that I'm aware of.

DR. ROWE: Depending on the way the contracts are written, you can be subject to autonomous increases in charges on the part of the hospitals, just to rev up their chargemaster payments and stop-loss provisions are generally being removed from hospital contracts. Or

many private insurers sell stop-loss insurance as well was regular insurance so it gets very complex. I think that the private insureds are less vulnerable than the Medicare system in general and becoming increasingly less vulnerable all the time because of changes in the way the contracts are written.

DR. MILLER: I guess this is a question. If you're a hospital and you raise your charges, that's a negotiating position for private payers, the private payers will come in and say I want a discount off charges. So to the extent that you've raised your charges, you're positioning yourself for that. And to the extent you're doing that and the cost-to-charge ratios lag a couple of years, that just drives more money into the outlier payments on the Medicare side. Is that right, Chantal?

DR. WORZALA: Yes, that's certainly fair.

DR. ROWE: What is clear is the system is broken. The point that Glen made about this being a distribution of -- did you see these services, EKG. I mean, these are very low-cost services that somehow should be getting paid for in the base rate.

MR. HACKBARTH: I think we need to move ahead, Chantal. So let's turn to the recommendation.

All opposed to the draft recommendation? All in favor? Abstentions?

Okay, thank you.

Let's now turn to the hospital update recommendations. Yesterday we had a lengthy discussion and I'd characterize it as follows: I think there was agreement on the substance of what we ought to do, which is to recommend a market basket increase for both the inpatient and outpatient rates, but varying ideas about how to characterize why we're doing that step.

What I'd like to do is just go back and review a couple of things and offer a formulation that we would include in the body of our report and this benefits from many conversations that I've had with individual commissioners.

Let me begin when the payment adequacy framework. We have a two-step process where we look at the adequacy of the rates and then a second step that looks at how much they ought to be increased for the next year. In that second step, we of course include

the estimated increase in the hospital market basket and then two additional elements. One, an expectation for improvement in productivity. And then second, an allowance for cost increasing but quality enhancing technology.

In talking to commissioners about this before and after yesterday's meeting, it's clear to me that people believe that these are reasonable and appropriate steps, the expectation for productivity and the allowance for new technology. I think that they are reasonable and we ought to continue them in the future.

Let me focus for a second on the productivity adjustment in particular. As we say, it's an expectation that there will be continued efforts and success in improving productivity. But beyond that it's a statement that the taxpayers ought to share in those gains. As I see it, simply what we're trying to do here is mimic what would happen in a competitive market where, in fact, the purchasers do share in the gains from improved productivity.

So the framework I have been comfortable and I continue to be comfortable with and expect to retain it

into the future.

Now having said that, I think for 2005 it would be a prudent step to forego making those adjustments or productivity and technology. Not abandon them, but prudent to forego them for this year's recommendation. Why is that? I think we face a complex and changing picture, one that's a little different than at least we've faced recently when examining hospital financial performance. And not all of the indicators point in the same direction, which is part of the reason that it's so challenging and complex.

As part of our analysis we, yes, of course, look at hospital margins but we look at other factors as well in making our determinations about payment adequacy, including access, quality of care, what's happening with access to capital and capital investment. And not all of the signals are in the same direction. Yes, we have evidence of declining margins but access to care continues to be good. Generally, the information on quality is good although there are some exceptions to that. There's been a significant increase in capital investment which would suggest that hospitals and

lenders are feeling reasonably good about their prospects.

We do have, however, a significant decline in the margin, the projected margin, and a fair amount of uncertainty about cost trends, and even some degree payment trends as a result of provisions in the drug reform legislation, that in my judgment at least create more than the usual amount of uncertainty.

So given that complex picture, as I say, I think the prudent thing to do is not to abandon our framework but rather for this year to forego the two adjustments, one for productivity and the other for technology. We will continue to examine the data, try to better understand what's happening with the cost trends, examine the somewhat different distribution of winners and losers that we have now than we've had in the past. As always, this is an ongoing process. We're not making a decision for all time but rather one that we will necessarily come back to again next year.

So that's my thinking about why this is the appropriate recommendation and I'd open it up to discussion. Nancy Ann?

MS. DePARLE: I thought about this a long time last night and reread the materials and I think for all the reason you stated --- I won't repeat everything you said -- but that this is the best place for us to be.

I thought the discussion yesterday was helpful and informative and useful. But I think the better way to handle this is just in our explanation of the chapter to give some of the details that you've articulated as opposed to trying to change the recommendation around and get into the adequacy of payment on those issues. So I would strongly support moving forward with that recommendation.

MR. HACKBARTH: Any other thoughts? Okay, let's proceed to the vote then.

All opposed to the recommendation? All in favor? Abstentions?

Okay, thank you.

MS. RAPHAEL: What about the outpatient?

MR. HACKBARTH: All opposed to the outpatient recommendation? All in favor? Abstentions?

Okay, thanks, Chantal.

Next up is ambulatory surgical centers.

MR. WINTER: Good morning.

I'll be reviewing our assessment of payment adequacy for ASC services and our draft recommendation for updating payment rates for 2005.

I'll also be discussing draft recommendations on revising the ASC payment system and the process by CMS decides which procedures to pay for in an ASC.

I will quickly review our analysis of payment adequacy based on the following four factors: it appears that 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.

Next, we'll look at the increase in the supply of providers and some new data that we've been working on to characterize ASCs. We're going to move on to a couple of other slides and come back to the framework in a couple of minutes.

So as of June 2003 there were over 3,700 Medicare certified facilities, an increase of 50 percent

from 1997. Most of the new and older ASCs are for-profit freestanding providers located in urban areas.

At the Commission's, request we attempted to identify ASCs by the types of services they provide. We based our analysis on Medicare claims from 2002. We encountered some data problems that limited the scope of our study, but I'll present what we were able to find. To ensure that we had an adequate number of claims to characterize each ASC, we selected ASCs with about 1,000 total claims. About 1,150 ASCs met this threshold, which is about one-third of all ASCs. These high-volume centers accounted for two-thirds of Medicare volume and payments to ASCs. We defined an ASC as single specialty if at least 90 percent of its Medicare payments were related to one physician specialty, such as ophthalmology or gastroenterology. We found that over half the centers met this definition of single specialty.

This table shows the number of ASCs in each specialty category as well as each categories' share of high-volume centers and Medicare payments. There's an error in the bottom row under the column percent of

high-volume ASCs. those numbers should sum to 99 rather than 95, as shown.

Over 40 percent of high volume ASCs were in the general category which means that fewer than 90 percent of their payments were related to one specialty. However, most of the general ASCs received a majority of their Medicare revenue from ophthalmology or GI procedures. One-third of ASCs specialized in eye procedures and almost 20 percent in gastroenterology procedures. Although we are unable to identify the age of each ASC, 90 percent of these facilities submitted Medicare claims in the previous year.

The next question is whether Medicare's share of an ASC's volume or revenue varies by its specialty type. Unfortunately, the most recent source of data on Medicare share of overall volume by service is from CMS's 1994 survey of ASCs. This reinforces the importance of collecting more recent ASC data.

The survey data show that Medicare accounted for 40 percent of all services covered by Medicare in an and ASC. Medicare's share of ophthalmology procedures was about 75 percent and its share of GI procedures was

about 40 percent.

Now we're going to go back to our update framework on slide two. We're now going to be on the third bullet. We found rapid growth in the volume of services provided by ASCs to beneficiaries. Between 1998 and 2002 annual growth of ASC services averaged 15 percent. By comparison, there was about 2 percent average annual growth of ambulatory surgical services in outpatient departments over the same period.

Finally, we found that ASCs have sufficient access to capital. These factors suggest that Medicare's payments to ASCs are more than adequate to cover current costs.

In the next part of the update framework we look at changes in the unit cost of ASC services for fiscal year 2005. The ASC payment system uses the consumer price index for urban consumers to approximate changes in input prices. The CPI-U is currently projected to increase by 2.4 percent in FY 2005. This is a more recent number than appears in your mailing materials. As with other provider sectors, MedPAC sets a policy goal for productivity growth of 0.9 percent.

Subtracting productivity growth from input price inflation results in an increase of 1.5 percent in the unit cost of ASC services. We believe that current base payments are at least adequate to cover this increase in cost.

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 a 1.5 percent increase in next year's costs. Because this would reflect current law, they would be no spending implications. And we do not believe that this would affect ASCs' ability to provide services to beneficiaries.

The next question we'll look at is how to revise the ASC payment system. The new Medicare law requires the General Accounting Office to study the appropriateness of using the outpatient PPS procedure categories and relative weights for the ASC system. The law requires the Secretary to implement a revised ASC payment system no earlier than 2006, fix taking into

account the GAO report. I will quickly review the main issues involved in basing the ASC payment system on the outpatient system.

Using the outpatient procedure groups would expand the number of payment groups for ASC services, which could enhance the accuracy of ASC payments. There are significant variation among rates in ASCs and outpatient departments for some surgical services which could create financial incentives for providers to shift services to the profitable setting. Using the same grouping of services and weights in the ASC and outpatient payment systems would likely make the weights more comparable, thus minimizing these financial incentives.

Due to competing agency priorities and Congressional action, CMS has not implemented revisions to the ASC system since 1990. Linking the two systems would allow CMS to update ASC procedure groups and weights each year, along with its annual revisions to the outpatient PPS. This should reduce the long delays between revisions to the ASC system.

However, this approach does raise some

concerns. The outpatient weights 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. Given data limitations, however, it doesn't seem practical to set separate rates for each individual procedure.

Another concern is that currently base rates in each payment system sometimes cover different bundles of services. For example, outpatient departments may receive additional pass-through payments for new devices which ASCs do not receive. On the other hand, ASCs can bill separately for prosthetic devices used in surgical procedures unlike outpatient departments. When CMS revises the ASC payment system, it should address these variations.

If we use the outpatient weights for the ASC payment system, how should we set the conversion factor or average payment amount? The new Medicare law requires that total payments under the new system be equal to total projected payments under the old system. Thus, the conversion factor would be based on the level of payments under the old system, which may not reflect

ASCs' costs.

One of the Commission's principles is that Medicare payment rates should reflect the costs incurred by efficient providers. If the conversion factor is to reflect costs of efficient ASCs, then CMS will have to collect recent ASC cost data.

This leads us to our next draft recommendation, which has three parts. First, the Secretary should revise the ASC payment system so that its relative weights and procedure groups are consistent with those in the outpatient prospective payment system.

Second, the Congress should require the Secretary to periodically collect ASC cost data to monitor the adequacy of ASC rates and develop a conversion factor the reflects the cost of ASC services.

Third, the Congress should ensure that payment rates for ASC procedures do not exceed outpatient PPS procedures for the same procedures, accounting for differences in the bundle of services. Thus, outpatient rates would be the ceiling for ASC rates, even if we find that ASCs incur higher costs.

We are unable to estimate the spending implications of this recommendation. ASC rates that are currently 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.

We also cannot predict the net impact on beneficiaries cost sharing. Our recommendation assumes that co-insurance would remain at 20 percent of the total ASC payment rates. The co-insurance amount would increase for services where the rates increase and decline for services where the rates decline.

In terms of provider implications, ASCs that focus on services that are currently paid more in ASCs than outpatient departments would experience payment reductions. However, ASCs that provide services currently reimbursed at much lower levels, such as some orthopedic procedures, might receive higher payments.

The next issue is how CMS decides what procedures to pay for in an ASC. CMS is required by statute to maintain a list of services that are payable by Medicare 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. They cannot exceed certain time limits for surgery, anesthesia, and recovery, and they also have to meet certain clinical safety criteria. For example, a procedure is excluded if it results in expensive blood loss.

Although CMS is required to update the list every two years, it was not updated between 1995 and March 2003. Long gaps between updates make it difficult for the list to keep pace with technological changes that enable ASCs to safely provide additional services. Some of the criteria, such as the volume of a service in inpatient settings, may no longer be relevant for determining what services are clinically appropriate to perform in an ASC.

Instead of maintaining a list of services that are eligible for payments, it might make sense for CMS to create a list of services that are specifically excluded from payment. For example, CMS maintains a list of inpatient only services that are excluded from

payment in hospital outpatient departments. When considering what ASC services to exclude from payment, CMS should continue to apply clinical safety standards. It should also exclude services that are likely to require an overnight stay to ensure that ASCs only perform ambulatory procedures.

To avoid creating financial incentives for services to shift from physician offices to ASCs, CMS should exclude 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 direct the Secretary to replace the current list of approved ASC procedures with a list of procedures that are excluded from payment based on clinical safety standards, whether the service requires an overnight stay, and payment differences between ASCs and physician offices. We propose that this changes occur only after CMS has revised the ASC payment system and reduced payment disparities between ASCs and hospital departments.

There are two main goals of this recommendation, to give physicians greater discretion over where to provide a service, and to make it easier for ASCs to keep up with changes in clinical practice and technology that allow more services to be safely provided in ambulatory settings. There is a risk that if the list is not kept up to date, this change might encourage the migration of some procedures to ASCs that are inappropriate for beneficiaries in that setting. However, ASCs have to meet minimal safety and quality standards to obtain accreditation and Medicare certification, which should mitigate this risk.

This recommendation could increase Medicare spending if more surgical services over all are performed beyond the shift of services from other settings to ASCs. Of the other hand, if ASCs are paid less than outpatient departments under a revised system, Medicare spending could decline if services shift from outpatient departments to ASCs.

ASCs would likely be able to provide a broader range of services, thus offering beneficiaries an additional choice of setting. 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.

DR. NEWHOUSE: Do you want to take the recommendations in order or do you want to just -- my comment is on recommendation two.

MR. HACKBARTH: For purposes of the discussion, we'll just treat them as a group.

DR. NEWHOUSE: Could you go back to slide nine, Ariel? So what is being proposed here is that, in effect, we take the outpatient PPS payment system with a different conversion factor. What I'm concerned about is that the weights is the first concern there, the weights may not be right. The reason I'm concerned about it is that we have all of these single specialty ASCs. In the outpatient side, the joint costs that go across different procedures get spread around into the weights. Those may not be appropriate for the ASC.

I don't have a problem with going with the recommendation but I would like to, although given the administrative load on CMS I'm reluctant to say this,

but I think at some point we need to have some data on what the right weights are for the ASCs, at least to back up our assumption here that the outpatient weights are approximately right.

What I'm concerned about actually is advantage number two up on this slide is actually only an advantage if the relative weights are correct. If the relative costs in the ASC is different relatives than in the outpatient department we could potentially be enhancing financial incentives to shift services. I don't think CMS can do it now given the load it has, but at some point we need to say that there needs to be some real data in the system on what actually are the weights that are appropriate for ASCs.

DR. MILLER: I think that's the second element of the recommendation number two.

DR. NEWHOUSE: It doesn't say anything about weights. I got this to get to the conversion factor advocacy and not the weights.

DR. MILLER: That's fair but I think in some of our discussions it seems to be we've gone around this true a little bit. Once you get the cost data you could

actually go through the process of running it through the OPD categories and determine how the weights actually compare to the OPD weights.

MR. WINTER: Right. You could think of this as sort of a starting place. They start off using the outpatient weights in groups. And then once you get ASC cost data, you could adjust, calibrate, those weights based on what the data show. And the GAO study is supposed to consider data submitted by the ASC industry and that might also shed light on adjustments that you might want to make in the weights and the procedure groups.

DR. NEWHOUSE: Depends on what you mean by ASC cost data. Obviously you need more than total cost. You need some way of allocating those costs down to procedures. It's not clear just from saying -- I mean, you can put this in the text, but collecting cost data is going to get to there. It's a puzzle. The question is what kind of cost data would you collect that let you set the weights?

DR. MILLER: For example, the GAO report that mandated in the legislation to collect cost information

on ASCs.

MR. WINTER: It's supposed to consider data submitted by the industry. So I guess you could do it that way.

DR. MILLER: It's not clear that would come in by procedure, for example?

MR. WINTER: The legislation does not specify that level of details for cost data. And it did repeal, eliminate the requirement on CMS to do a survey every five years of ASCs' costs, which is why this part of the recommendation is very important. And maybe we could specify that, the Secretary should periodically collect ASC cost data at the procedure level to address Joe's concern.

DR. ROWE: Ariel, I'd like to have a little more discussion about recommendation number three, particularly some of the issues about excluding from payment based on payment differences and some of the other requirements, and the issue of what can get done in a physician's office versus what can get done in an ASC and what can get done in an outpatient department.

My experience is a little different. You

write about the fact that ASCs are more costly, more specialized, they may be. My experience this was always about a bargaining unit issue, this was a labor relations issue. That, in hospitals that were unionized, which is the setting that I worked in, the ASC was not unionized. That the ASC was owned more than 50 percent by somebody else, and therefore the salaries and the benefits or whatever else was associated with that were very different, the input prices were lower.

And the doctors offices were on the medical campus. And therefore the people who worked in the doctor's offices were in the unit. I'm not saying that's good or bad. I'm just giving you an experience.

So things were actually quite a bit in a different direction than we maybe assuming here, in terms of the cost of doing something. And I'm not sure that influences the recommendation. It's one of the issues here and we might want to think it through.

But what I want to make sure is that the physicians actually really have more discretion and the patients have more discretion about where to do a given procedure because my feelings are that the patients who

get colonoscopies vary a lot, and some of them are really healthy 50-year-olds who get one for their 50th birthday as a screening procedures. And others are frail people with a lot of diseases and comorbidities and medications and you just take one look at this patient and say I don't want to do this in my office. But they look the same to Medicare from the point of view of the charge or whatever.

So just explain to me that we're not excluding paying for a procedure to be done in an ASC just because it could be done in a doctor's office and the doctor prefers to do it in an ASC because of the condition of the patient. Just assure me we're not doing that because that's the way I interpreted this.

MR. WINTER: The concern here is that if you allow more procedures to be done on particularly more basic procedures that may not require the specialized setting of an ASC, such as a dedicated operating room and recovery room, that you might encourage physicians to open up an ASC next door to capture the higher facility payments for an ASC for that procedural when the additional infrastructure of an ASC may not be

needed for an average patient.

Now I understand what you're saying for a sicker patient.

DR. ROWE: I'm looking at it from the doctor's point of view and the Medicare beneficiaries. We want to make sure that clinically we get this done in the safest, most appropriate environment. Now it may be that that environment is going to be replete with other resources that aren't needed to do a safe colonoscopy in an 87-year-old frail patient. But as a doctor or the son of the patient or whatever, I don't care about that. Just don't tell me that this guy's got to do it in his office where there's no anesthesiologist around and where he does two a week or something because he can't get paid if he does it in the ASC. That's the way I was interpreting this recommendation. Maybe I'm wrong.

MR. WINTER: That physician could still do the procedure in the hospital outpatient department if the ASC were not available.

DR. ROWE: Not everybody can do that. That's not ubiquitously available to every practicing physician. Or maybe an ASC. It varies, I guess is my

point.

I'm just trying to look at this clinically rather than the financial incentives. I don't know that there's a solution here. I'm just concerned about it.

What if the hospital outpatient department stopped doing these things because they owned the ASC? They just say we're not going to have this duplicative redundant infrastructure and the only such-and-suches we're going to do are inpatient. And if they're outpatient, they're going to get done in our ASC which is around the corner? Then the guy is stick, right?

DR. STOWERS: This may be an obvious question but when you say replace it with the outpatient procedure list, are you limiting that to surgical procedures or are we going to throw in CAT scans with contract or all the other things that are done in the outpatient departments?

MR. WINTER: In terms of allowing them to be done in ASCs?

DR. STOWERS: Right.

MR. WINTER: That's not our intention. Our intention is to continue to limit the ASC procedures to

ambulatory surgical services and not include radiology and other services.

DR. STOWERS: We may need to make that clear because that outpatient procedure list has all sorts of things on there that would really open Pandora's box because there's a tremendous price difference between getting a CT scan done in the outpatient department or getting it done in a community x-ray center by three-to-one in costs. So if we were to throw all of those into this procedure list, it would totally change the complexion of all of this. So we may want to make it clear we're still talking just surgical outpatient procedures.

MS. DePARLE: Generally, I think the recommendations are moving in the right direction and I just had a couple of comments.

On number three, I think I said this the last time but I'll just say it again. I'm really glad that I think we've come up with something that makes a lot more sense than what CMS has been trying to do, and not very successfully. I think this area has really been neglected by CMS, for lots of reasons including the ones

that Joe and others have pointed out, which is that they simply don't have the resources given everything else on their plate to keep up with this.

I think what we're doing is moving this where it should be, which is more towards a clinician making a clinical judgment in the way that Jack described. You could also make the argument, subject to Ray's caveat, that anything that isn't on the inpatient-only list should be open here, that is should be a matter clinical judgment.

But in any event, I think this definitely moves in the right direction.

Our second recommendation, I will support it but I just would note that I have a slight misgiving even as you've modified it in that Congress stated a month ago, I guess, that this new payment system should be budget neutral. My experience, from having implemented a number of new payment systems, is that when they are budget neutral it is far easier to get it done, to work with the industry to get it done.

Now, you may have lots of changes underneath the overall baseline spending so that some things will

move in one direction and some things will in another. But that it's far easier to implement. And then in the end you actually do get behavioral changes that move in the direction that you want.

So while I'm not going to vote against this, I do caution that that may have been why Congress chose to say this thing should be budget neutral. And what we're trying to do, I think, may make it more difficult to achieve our objective.

MR. SMITH: Ariel, thank you. This was a very good job.

I want to return to the question Jack raised about recommendation three from a slightly different angle. His discussion about whether or not things are organized or not, I'm going to avoid.

But I did wonder, Ariel, why we didn't apply the same principle of ceiling price that we thought about with respect to OPDs and ASCs, why we didn't apply the same principles to the issue of physicians' offices? If we use the physician office payment as a ceiling, why wouldn't we want to have the option of having the procedure performed in an ASC, as well, with that

caveat? Partly addressing Jack's clinical concerns, but also trying to establish neutrality in site of service here. So we both open up the possibility of a more sophisticated setting, but we don't introduce the possibility of site shifting simply on the basis of payment rates.

So unless I'm missing something, it would seem to me that we ought to see if we can deal with the third bullet there, the payment difference between ASCs and physicians offices to apply the same ceiling principle we used in the earlier recommendation with respect to ASCs and OPDs.

MR. HACKBARTH: Ariel, do you have any reaction to that idea?

MR. WINTER: I'm trying to think about whether to add it to this recommendation or have it as a separate free-standing recommendation. I guess we could eliminate the third bullet under this recommendation and say procedures that are routinely and safely performed in physician offices can be performed in ASCs, but would be paid at the physician office practice expense rate if it's commonly done in the office setting.

MS. DePARLE: Then what would you do to -- there probably is some set of procedures that could be performed in a hospital outpatient department, an ASC, or a physician office. I think we all support the idea of a level playing field here, but I don't have any sense of what the impact of that would be in terms of payment, do you?

MR. WINTER: We'd only do it for services where -- one thing you could do is only set that rule for services where 50 percent or more of the ambulatory volume is in a physician office, but then you would still have a big gap between the physician office -- probably a big gap between the practice expense rate in the physician office and the outpatient facility rate.

MS. DePARLE: Right, but then are we suggesting that we should lower the hospital outpatient payment, if a lot of these things could be performed safely in a physician office? I think that seems like we're introducing a whole new, perhaps very interesting, but a whole new element to this.

MR. WINTER: I think before we consider doing that, we'd have to look at the patient mix in each

setting and the regulatory burdens and quality in outcomes. This is part of our longer-term agenda for payment differences across settings for the same service. So we may want to wait and think some more about that before heading into this area.

DR. ROWE: I think that there are the same issues about what the payment scales are and the benefits, and all kinds of different things.

MS. RAPHAEL: Ariel, just a clarifying question. Why are we saying that this has to occur after the ASC payment system is revised? Because I look at this as a very separate set of activities that are clinically driven. So I don't understand the bridge between the two.

MR. WINTER: One of the concerns about opening up the ASC list or allowing more procedures to be done in ASCs that are currently being done in outpatient departments is that under the current ASC payment systems there are big disparities in payments in both directions.

But we're more concerned about cases where the ASC payment rate is higher than the outpatient rate. So

if you allowed more procedures to be done and those rates ended up being higher than the outpatient rate, then you might encourage the migration of procedures to the ASC setting for financial rather than clinical reasons. But it depends on what -- what payment group would you put the new procedures in? That's the big question.

And CMS struggled with that when they expanded the list in March of last year and they ended up not including new procedures on the list for that reason, because they didn't know what group to put them in. Even in the lowest paid ASC payment group, they would still be paid significantly higher than the outpatient rate. That was the issue. So based on the current architecture of the ASC payment system, it could create problems when you try to allow new procedures to be done in the ASC setting.

DR. WOLTER: I also thought it was an excellent chapter and the recommendation is in the right direction. I have two concerns.

One is we state again that we would like in both the ASC and the hospital outpatient setting for

costs of efficient providers to be covered. In one case we don't have any cost data. And in the other case we either don't believe it or aren't sure how to interpret it.

And I can't help but point out once again that we need to decide are we going to wrestle with that issue on the outpatient hospital side as well as the ASC side or not, because it leaves us in a position of making decisions year-to-year based on a framework that we can't really use because we don't have the data that we believe.

My second concern, which I haven't really seen raised but it concerns me. And that has to do with self-referral and utilization patterns over time when physicians are significant owners of a facility. I don't know whether that should become part of our agenda ever or whether it's being looked at by someone else. But I think it's an inevitable question that's going to be raised as this movement continues over time.

DR. ROWE: [off microphone.] These are the safe harbor, the Stark privileges.

MR. HACKBARTH: In fact, it might be useful

Ariel for you to just quickly summarize what the rules of the game are right now.

MR. WINTER: Sure. The Stark legislation prohibits physician self-referral, prohibits Medicare and Medicaid payments -- it prevents a physician from self-referring to an entity in which they have a financial stake. And there are nine health services that are excluded from physician ownership but ASCs are not on that list.

The other relevant legislation is the anti-kickback law, which is much broader and covers all health care services and prohibits remuneration or any kind of incentive for physicians to perform a service. And there are safe harbors that allow physician ownership of ASCs under the anti-kickback law.

DR. MILLER: So the punchline is right now there is an exemption in the Stark rule for the whole hospital exemption, and essentially, once you troll through all of this, for ASC; is that right?

MR. WINTER: That's right.

MR. HACKBARTH: That's the piece I don't understand. I understand the logic of the whole

hospital exemption being that an individual's decisions about where to send a patient are small in the context of a large institution. That doesn't seem to apply to ASCs which can be much smaller and very specialized. So the risk that the Stark law is directed at seems to exist in the case of ASCs and why are they not covered?

MR. WINTER: I think the logic initially was that when the Stark law was enacted in the early 1990s, actually the first one was 1989, the government was trying to encourage the growth of ASCs because they were seen as a less costly alternative to outpatient departments and inpatient hospital settings. And most ASCs at the time were owned by physicians. They were the main source of capital for ASC development. So if you prohibited physician ownership of ASCs, you limit the growth of ASCs. And that was the concern in the late '80s. And the market has obviously changed a lot since then so it might be worth revisiting.

MR. HACKBARTH: I'm with Nick on this. I have some concerns about that issue as well and whether the current rules make sense in the world as we now know it.

DR. ROWE: I think practically, it's quite

striking when you read the legislation. It's been sitting out there a long time. This didn't just happen. And it specifically exempts ASCs. And I think the issues were clearly that if a hospital -- the way these are usually done, they are owned by physicians but not to get the capital. There's generally a business partner who makes a capital contribution and who manages the facility and there are a number of these very effective, highly ethical, very productive organizations around the country that do this.

And what they'll do is go to a hospital or community and identify a group of physicians who are heavy
utilizers of these kinds of services. And say you guys are doing this in your office, you're doing it in the hospital outpatient, and the hospital doesn't have the money to update its outpatient department and you've been complaining for 10 years that the suite is archaic and unsafe and it's more and more expensive for you to do this in your office. And we'll give you the capital if you guys come together as a group.

But of course, you realize that the patients

that are going to get treated here are the patients who you treat. They're your patients. But we need you to set up the clinical rules and the oversight and the quality committee and the infectious control and all the rest.

So because of that kind of built-in conflict, these were exempted from the Stark anti-referral rules because if they weren't ASC growth would have been eliminated. And so that was the concern.

I served on the New York state committee that oversaw the CONs or whatever for facilities. Remember that, Carol. And this came up all the time.

And I would have to say my experience was that the physician input was vital to the quality and to running the thing in a clinically appropriate way. I can't imagine how it could be done otherwise. So I know it does give you the self-referral thing, but in fact, they were referring these patients to themselves before. In other words, they were doing it in their own office. The patient would come and get a colonoscopy. That's what they were doing.

MR. HACKBARTH: You've clearly explained the

historical rationale. Would you leave it that way?

DR. ROWE: Let's say I'm a gastroenterologist and you sent a patient to me and the patient is pretty sick and frail. And there's an ASC where I could do the procedure or I could do it in my office. And I can't send the patient to the ASC because I'm on the board, or I'm an part-owner of the ASC, and all my partners are, and all the gastroenterologists in town are.

So then I tell the referring doctor, Dr. Nelson, I have to send your patient to Pittsburgh to get a colonoscopy because all the doctors in town -- I mean it's just stupid.

So sure, I'm sensitive to Nick's concern. And we saw that with imaging centers. Doctors owned imaging centers and patients would come in and then a lot of people were getting CAT scans and there were questions about whether or not the right clinical criteria were being applied. I remember those bad old days.

But in this particular case, unless there's evidence to the contrary, I think it seems to work. Nick?

DR. WOLTER: I think you've explained well the

positive side of the story. I do think that in recent years we're seeing an explosion of these. I'll tell you in Billings we have about four of them now, or a fourth one was just announced. I think, especially when there's a high volume of single specialty ASCs, at least the question of utilization should be raised.

I think that now that this has become a much bigger movement and we're seeing a lot of dollars being invested in duplicate infrastructure, and in fact, many of these patients maybe come from what was previously in the office but many are also coming out of what was previously done in hospital outpatient. And I don't know the sustainability of this over time, quite frankly. It's become a major economic movement. And I think there are pros and cons to this, and you've outlined those well.

I do think we're going to need to monitor this.

DR. REISCHAUER: Jack gave us the example of some procedures that could be done in a physician's office as well as an ASC or an outpatient. But there's a lot of procedures that can't be done in a physician's

office and the choice is simply between hospital outpatient and an ASC. And that's a different trade-off.

DR. ROWE: Yes, that would be significantly different and I view those differently.

MR. HACKBARTH: Jack, your description has been helpful. What I'd like to do is learn more about this and think about it some more. There will be other opportunities, I think, to take up the self-referral on a piece of this, either in a discussion of ASCs in particular or maybe in some other context as well. So let's hold off on that for now, Nick, if that's okay with you, and focus on the three recommendations before us.

Any other questions or comments?

Why don't you put up number one. All opposed to recommendation number one? All in favor? Abstentions?

Now help me out on number two. I know we had some discussion about this. Are there any modifications we want to make?

DR. MILLER: I think in response to Joe's

comment, the modification is in the second bullet point. It would read something along the lines of the Congress should require the Secretary to periodically collect ASC cost data at the procedure level to monitor adequacy, et cetera.

MR. WINTER: Can I suggest one other change based on comments? To continue on from where Mark left off, to monitor the adequacy of ASC rates, calibrate the relative weights, or monitor the relative weights, and develop a conversion factor that reflects the cost of ASC services.

MR. HACKBARTH: We can tinker with the language but I think the intent is pretty clear. Do people understand what we're trying to get at?

So let's vote on number two with that modification in mind. All opposed to number two? All in favor? Abstentions?

Okay, number three. Any modifications on this one based on the discussion?

MR. WINTER: One suggestion from David, I believe, was to take out the third bullet and add a sentence that says payment for services that are

routinely provided in physician offices should be no higher than the physician practice expense office rate.

MS. DePARLE: I don't feel prepared to vote on that today. I don't think I have any idea what the implications of that might be.

MS. RAPHAEL: I was just going to suggest we pull out the last one, payment differences, because we're trying to do this in a clinically -- to me -- defined way having to do with safety and overnight stay. And then all of a sudden we drop in there payment differences.

So I just think that one has to come out for this to make sense in terms of trying to figure out what procedures should be approved or excluded. And then whatever we do on this, I think we should do separately.

I was persuaded by what Ariel said that there were some really compelling reasons not to go forth with this because of payment implications.

MR. HACKBARTH: The proposal on the table is to delete payment differences between ASCs and physician offices.

MR. SMITH: That would accomplish, I think,

what Jack and I were trying to get at, that the exclusion list here ought not to be based on a payment consideration. And simply removing that would take care of it and it would allow the clinically appropriate decision to be made without having excluded the ASC option on the basis of a payment difference. That would accomplish what I think I wanted to do.

DR. REISCHAUER: But do we want the text to reflect that this is an area of interest and further analysis by us? Because I would think we would.

DR. ROWE: Also, really you can't have it the way it's written because if you use the example I gave of the pretty frail, multiply impaired, functionally marginal patient then the clinical safety standard indicates yes and the payment difference indicates no. So then you have to have some mechanism to say well, if one of these says yes and the other says no, how do you determine which is subordinate to the other?

MR. HACKBARTH: I think that makes sense to delete that third item and focus on the clinical considerations in the note in the text that we'll come back and think about the other issue.

With that modification, all opposed to recommendation three? All into favor? Abstentions?

Okay.

MR. FEEZOR: Glen, just to underscore your comment, the issue on Stark or other incentives or disincentives, I'd like to put that as a potential issue that we might plow into a little more somewhere offsite, potentially.

MR. WINTER: Allen, we do plan to address this issue as part of our study of specialty hospitals, which is a Congressionally mandated study under the new Medicare law. So we'll be looking at it in that context and we can certainly think about it for the June retreat, as well.

MS. DePARLE: But Glen, when we're looking at it, and Allen and I had a chance to talk about this some yesterday, we also want to make sure we're looking at it in the context of the things that we're trying to do on quality because we both think that until you allow physicians' interest to be aligned with those of hospitals and other providers that it will be hard to achieve some of the things we're trying to achieve.

Even in the two areas where we made those recommendations yesterday there are those issues. So it's multifaceted.

MR. SMITH: Glen, on the same subject, as Nick was raising his concerns a minute ago, I think there are two issues here and they're not entirely covered by the self-dealing, self-referral Stark provisions.

The other one is the cannibalization question and whether or not that has an impact on the viability of the hospital setting which needs to be viable for a variety of other functions. Does the development of this additional infrastructure have implications for the architecture of the rest of the system that we ought to pay attention to?

I don't have a view about the answer to that, but I think that question is as important as the potential conflict, self-dealing, kick-back questions.

MR. HACKBARTH: Mark was just saying that one is a significant part, I think, of the specialty hospital.

DR. STOWERS: [off microphone.] I don't know if we need to get into service that requires an

overnight stay. We could just say based on clinical safety. We've already voted on it, but I'm just saying you don't need the bullets under it.

MR. HACKBARTH: All right, we're going to change gears now for our last two agenda items: long-term care hospitals and dual eligible beneficiaries. These are both parts of the June report so we are out of the process of voting on update recommendations for March and looking a little further down the road. Sally, whenever you're ready.

DR. KAPLAN: Good morning.

The purpose of this presentation is to bring you the results from two qualitative studies of long-term care hospitals.

As you know, qualitative research has limitations. Results cannot be generalized because samples are generally small and opportunistic rather than randomly selected. In addition, informants frequently are not objective. Nevertheless, when used in conjunction with quantitative studies, qualitative research provides context and color to enable policymakers to have a better understanding of an area.

In the first study, NORC and Georgetown conducted 34 interviews with physicians, hospital administrators, nurses, and discharge planners in market areas with and without long-term care hospitals. Interviews focused on treatment and referral patterns of patients requiring a high level of care for an extended period of time. The principal investigators of that study are in the audience if you have questions about the interviews that I am unable to answer.

For second study Dr. Nick Wolter and MedPAC staff visited three cities: Boston, Houston, and New Orleans. Dr. Norbert Goldfield, a physician from 3M who is very familiar with long-term hospitals, accompanied us to Boston and Houston. Pete DeBusk accompanied us to two long-term care hospitals in New Orleans. In all physicians from 10 long-term care hospitals presented profiles of patients in a grand rounds format, providing information about each patient's condition, acute hospital stay, admission to the long-term care hospital, treatment, and discharge.

The results I'm presenting today address the three research questions on the screen. These are three

of the five research questions we've consistently asked in this study. These ask about the role of long-term care hospitals, about how patients are treated in areas without long-term care hospitals, and about outcomes.

Long-term care hospitals provide post-acute care in to small number of stable, medically complex patients. Many patients require ventilator little support, have multisystem failure, neuromuscular damage, contagious infections, or complex wounds needing extended care. Long-term care hospitals extensively screen patients. Representatives of these facilities maintain that they select patients who have a prognosis for improvement. They also screen for insurance and reportedly generally do not admit patients without insurance supplemental to Medicare. Medicare is by far the biggest payer for long-term care hospitals. Some long-term care hospitals have contracts with Medicaid, some have contract with commercial insurance. Long-term care hospitals have a feeder system of acute hospitals that refer patients. Acute hospitals benefit from being able to transfer patients to long-term care hospitals and are a major driver for the growth in these

facilities.

Interestingly, on site visits, we were told that physicians frequently are obstacles to transferring patients to long-term care hospitals, either because they do not understand the care long-term care hospitals provide, or they may believe they have to turn over their patients and lose control of their patient's care. Families also can be obstacles if they did not understand the difference between long-term care hospitals and a long-term care facility or nursing home.

Patients in areas without long-term care hospitals are treated in various settings. Some patients stay longer in the acute hospital. They are usually moved from the ICU or the CCU to medical or surgical beds. Usually these patients would be high-cost outlier cases.

Some acute hospitals have created units stepped down from the ICU level of care and these units treat patients similar to long-term care hospital patients. Some SNFs are adequately equipped to handle long-term care type patients. However, it is clear from everything we were told in both studies that fewer of

these SNFs exist under the SNF PPS. I'll talk more about SNFs in a moment.

On site visits inpatient rehabilitation facilities were not mentioned as an alternative to long-term care hospitals. However, NORC and Georgetown were told that some IRFs do accept patients similar to those treated in long-term care hospitals.

The biggest disagreement between what we were told on site visits and in the structured interviews concerned whether SNFs are capable of providing care for patients treated in long-term care hospitals. On site visits long-term care hospital representatives were adamant that SNFs could not care for long-term care hospital patients. They pointed to long-term care hospital patients' need for daily active intervention by physicians who are available seven days a week in long-term care hospitals and not routinely involved in SNF patient care. They also pointed to nurse staffing of six to 10 hours per day compared with five hours per day in hospital-based SNFs and three hours per day in freestanding SNFs.

In addition, they told us that most long-term

care hospitals have physical, occupational, speech, and respiratory therapists on staff and frequently employ specialist RNs.

Regarding patients requiring ventilator support long-term care hospital representatives told us that only patients who were stable but with little ability to be weaned were the type of patients SNFs could treat. However, in the structured interviews NORC and Georgetown were told that SNFs were the principal alternative to long-term care hospitals. They were told that some SNFs are adequately equipped to handle ventilator-dependent patients or others requiring a high level of care. These SNFs offer a level and intensity of care that some respondents thought comparable to that offered by long-term care hospitals.

NORC and Georgetown did more digging on this issue. In one market at least three SNFs provide care to ventilator-dependent patients. For example, one of these SNFs specializes in respiratory care and over half of its patients require ventilator support. Most of these patients have other complications such as major wounds, COPD, or multisystem failure. About one-third

of these ventilator-dependent patients are undergoing active or semi-active attempts to wean them from the ventilator.

This SNF has a pulmonologist medical director who rounds with the nursing and respiratory staff. There are two respiratory therapists onsite 24/7 and a respiratory care director at the SNF every day. A primary care physician makes rounds twice a week at this SNF.

One thing everyone agreed about was that SNFs capable of caring for costly patients are much less common since the SNF PPS was implemented. As you know, the SNF PPS overpays for rehabilitation patients but respiratory therapy does not count towards rehab in SNFs. It counts as an ancillary just like drugs and the SNF PPS does not cover the cost of ancillaries accurately.

NORC and Georgetown found mixed opinions about long-term care hospital outcomes. Some respondents reported that long-term care hospitals provided a valuable service to patients who needed extended acute care. Others told researchers that long-term care

hospitals could be overused when they admitted patients with little chance of recovery. Still others reported that long-term care hospitals postpone a timely discussion of end-of-life issues.

In standard outcome measures long-term care hospitals report wide variation on a hospital-to-hospital basis. On site visits, we were told that 10 to 33 percent of patients die in the long-term care hospitals and 35 to 90 percent of patients are weaned from the ventilator.

Regarding patient satisfaction, patients and families appear to appreciate the amenities at long-term care hospitals. Frequently there are private lives and/or rooms with windows.

As far as the next step in this research is concerned at the March meeting we plan to present results from two types of analyses, more multivariate analyses and policy analysis. The policy analysis will be designed to identify ways to better define long-term care hospitals and the patients appropriate for them.

I'm happy to take your questions or comments.

DR. REISCHAUER: Thank you, Sally.

MR. DURENBERGER: This will just be a brief comment without a question in it. As somebody who was concerned about this in the beginning, I'm really very, very impressed with the scope and the depth and the variety of approaches that are being taken here. And I'm totally impressed by the fact that Pete and Nick are going to go out and be part of it, and obviously looking forward to some of their reaction as you start moving towards the policy design and so forth.

But this is just so impressive to see this kind of a broad gauge support where we're not just looking at it from the standpoint of this institution with this name versus that one. But I sense that behind that you're really looking at the issues of patient care, and the family involvement, and the role of professionals, and some of those other kinds of issues which are really important for this particular population.

DR. REISCHAUER: I think we'd all like to associate ourselves with that comment.

MS. DePARLE: That's what I was going to say, too. And I think you very well describe the limitations

of site visits and more anecdotal research. At the same time I think it's vitally important that we get out of our offices and see what's changing and how these different providers are actually operating in the marketplace and serving beneficiaries.

Nick and Pete, thank you on behalf of everybody else for taking the time. I'll volunteer to go out with you. I've been to I think one in Philadelphia but it's been four or five years ago and I think I could use some updating, too. I think it's great work on the part of the staff.

DR. WOLTER: The one thing I would just say is to agree with that. This is a complex topic. I did not know much about LTCHs prior to these visits. And having gone up the site visits but not been part of the structured interviews, I was really impressed with how you all put this information together. So an excellent job.

MR. HACKBARTH: Any others?

Okay, thank you, Sally.

Last up is dual eligibles.

MS. MUTTI: This presentation introduces our

work plan and initial work on the dual eligible population. And that's those beneficiaries that are eligible for both Medicare and Medicaid coverage.

In addition to the briefing materials we sent you in advance of this meeting, back November -- and I'm not sure if you're going to remember this -- we did give you a preview of our work plan. So you've had some materials to get an idea of what our thoughts were on this topic.

I just want to take a moment first to talk about the reasons we felt that it was important to focus on this population. First, as many of you probably have noticed in numerous of our discussions on different payment policies, questions have arisen about how dual eligibles are paid for, what their care patterns look like, what their coverage is. And we're hoping that this agenda for work will answer many of those and probably raise others.

Secondly, the very nature of this population motivates us to put it on our agenda. These are a vulnerable and costly group of beneficiaries. In terms of vulnerability, by definition they are poor. They

tend to be more likely to be living alone, living in nursing homes, be disabled, have more chronic conditions.

In terms of costliness, they account for about 17 percent of Medicare beneficiaries but 24 percent of spending. In terms of total costs, they are about twice as costly as Medicare beneficiaries.

We also thought it was important because there's been a variety of policy changes that have been enacted in the last few years that may particularly impact this population, be it PPS's for post-acute care services, a prescription drug benefit, changes in how Medicaid is supposed to pay for Medicare cost sharing. All of these are important. And while we may not have the resources right now to examine each of these specifically, I think collectively we felt that they warranted closer attention to this population.

Lastly, there's a number of other issues that we're looking into, the implementation issues of the prescription drug benefit, disease management proposals, and both of those have implications for dual eligibles. And certainly going over some of the basics of this

population, who they are, how they are paid for, what their care patterns are, should help facilitate those discussions, also.

The work plan us up on the screen. The first two items, eligibility requirements and coverage and payment policies, we will be talking about today and we'll identify some of the issues that we've found so far in our look at that.

In the future, we plan -- and this is supposedly this spring -- we're going to be looking at the demographic characteristics of this population. We're particularly interested in teasing out the subpopulations within duals because it can be a somewhat diverse group. We'd like to look at their cost and use of care and compare that to other beneficiaries, and also look at access to care. And we're hoping to use MCBS and CAHPS data, if not some other sources to specifically look at responses by dual eligibles.

At this point, I'm going to turn it over to Sarah, who's going to talk about eligibility requirements and issues. then I'll come back and talk about coverage and payment policy. And then we look

forward to getting your comments, both on the agenda and the content of this presentation.

MS. LOWERY: About 90 percent of dual eligible beneficiaries qualify to receive full Medicaid benefits such as nursing homes or other institutional care, home care, or dental care in addition to their Medicare benefits. Beneficiaries can qualify for these benefits either by also qualifying for Supplemental Security Income, SSI, and meeting other asset requirements, or by being medically needy.

A beneficiary is considered medically needy if after deducting their medical expenses from their income they meet a state-specified level. Medically needy beneficiaries would not otherwise qualify for Medicaid since their income and assets are above the requirements, but they are essentially allowed to spend down their income to qualify. And they're also often called spend-down beneficiaries.

Medically needy beneficiaries often cycle into and out of the Medicaid program since their eligibility may change frequently. 39 states have medically needy programs through which states have the option of paying

the Part B premium, in addition to providing full Medicaid benefits.

On the other hand, states must pay the Part B premium and cost-sharing for beneficiaries who qualify through SSI, in addition to the full Medicaid benefits.

Additional programs, often called the Medicare Savings Programs, created four other categories of dual eligible beneficiaries. Qualified Medicare beneficiaries, QMBs, specified low income beneficiaries, SLMBs, qualifying individuals, QIs, and qualified disabled and working individuals.

QMBs, which make up 6 percent of dual eligible beneficiaries have incomes up to 100 percent of poverty and a higher asset level than SSI recipients and states pay their Part B premiums and cost-sharing.

3 percent of duals are SLMBs, who have incomes between 100 and 120 percent of poverty with the same asset requirements and states pay the Part B premiums.

QIs must have incomes between 120 and 135 percent of poverty, again the same asset requirements, and states pay some or all of their Part B premiums.

DR. NELSON: [off microphone.] Is an owned

home excluded in the assets?

MS. LOWERY: Yes. Yes.

States pay Part A premiums for qualified disabled and working individuals if they purchase Part A after they return to work and have incomes less than 200 percent of poverty but don't qualify for any other Medicaid assistance.

MS. DePARLE: Alan was asking me about the assets test and you answered one of the questions, but can you go back to that chart?

This may be too complicated, but how do the assets test under these various categories compare with what's in the DIMA for the subsidies for low income people? Are the asset tests the same, or do you know?

DR. BERNSTEIN: [off microphone.] States have different asset tests and some of those are similar to DIMA and some of them are significantly lower. Some of them are higher. They're all over the place.

MS. DePARLE: For DIMA it will be a nationwide assets test. So the state may have its own asset test for this purpose.

DR. BERNSTEIN: Right.

MS. DePARLE: And then also do the other one.

DR. BERNSTEIN: [off microphone.] They do set floors for -- the state's program has floors. But for full Medicaid benefits there are different assets tests that vary by state.

DR. STOWERS: Another thing, usually Alan, if they go into a long-term care facility, a nursing home or whatever, then they only get to keep their home for one year to be sure they're not going to get back out. But at the end of the year, the house has to be sold. And that asset goes into helping pay for their nursing home care, in most states.

MS. LOWERY: Eligibility and benefits offered to Medicare beneficiaries through Medicaid can vary greatly by state, as you just talked about. For example, states have the option to extend full Medicaid benefits to beneficiaries with incomes up to 100 percent of poverty. Some states do this and some do not.

Also, even if a beneficiary is eligible for Medicaid benefits, they may not be enrolled in the program because of various barriers to program participation or they simply may choose not to enroll.

Outreach to beneficiaries, simply educating them about the programs may not be effective and welfare workers, Social Security employees, and community-based organizations often don't have extensive knowledge about the programs.

The enrollment process itself can be long and complicated and often requires long waits in welfare offices, face-to-face interviews, and extensive documentation of income and assets that could deter beneficiaries from enrolling, as well as difficulties with language and transportation.

Beneficiaries may choose not to enroll if the state has Medicaid state recovery requirements and there's also a stigma associated with being on Medicaid which may prevent beneficiaries from enrolling.

Enrollment in Medicaid and the Medicare savings programs is often documented at significantly less than 100 percent of eligibles. For example, only about 16 percent of those eligible for the SLMB program are enrolled and estimates of beneficiaries who qualify for the QMB program range from 55 to 78 percent.

The differences that we have described in

eligibility and enrollment translate to differences in health care benefits which can affect access to needed care.

Now Anne will move on to coverage.

MS. MUTTI: By definition, dual beneficiaries have both Medicare and Medicaid coverage but one of key questions is which program covers which service. Medicare is primary, and by that I mean it pays first for the services that it covers in its benefit package. While that may sound somewhat straightforward, it really gets a lot more complicated because there's many dimensions to coverage.

For example, for a Medicare service to be covered it has to be provided by a Medicare approved provider, it has to be deemed to be medically necessary, it has to meet certain coverage criteria that certain services have like a three-day hospital stay prior to a SNF-covered benefit. Or the beneficiary has to be homebound before being covered by the Medicare home health benefit.

These examples raise the issue that there's a

lot of gray area, that we are guided by statute, and a lot by judgment, too, on intermediaries, on their part. And then if these decisions are appealed administrative law judges can get involved and then their judgment pertains here, also.

Medicaid is generally secondary. I just would note that there are some dual beneficiaries who actually have other sources of coverage and in that case they would be secondary. But for the vast majority, Medicaid is secondary.

It covers three types of health care costs. Medicare cost-sharing, and I'm going to come back to that in a moment because I will qualify that. Benefits that have been exhausted under Medicare or are not covered because of a certain characteristic is not met. And that may be hospital stay, the episode has been exhausted, or a SNF stay of 100 days in an episode has been exhausted. And thirdly, benefits not covered by Medicare, and this would include long-term care services, most of those, as well as at the moment outpatient prescription drugs. In 2006 Medicare will have its own prescription drug benefit and at that point

Medicare will be primary on that. And certainly implementation of that drug benefit raises a lot of issues for dual eligibles. And actually my colleague, fortunately, Joan, will be coming back to you to talk through some of those with you.

But at this point I thought it might just be useful to note that the benefit design of this prescription drug benefit is really quite a departure from other benefits in the Medicare package because it's the first time -- that we know of anyway -- that the generosity of the benefit varies by income of the beneficiary. So that the cost-sharing requirements for dual eligibles are quite a bit less than the cost-sharing requirements for higher income beneficiaries.

We'd also note that coverage issues are somewhat more complicated when duals are in M+C plans because these plans have different benefit and cost-sharing structures than under fee-for-service. These plans, the cost sharing structure varies by plan and the plans are increasingly charging premiums that are in addition to the Part B premium. And this raises some payment issues that I will come back to as we talk about

payment in M+C.

Turning to payment for beneficiaries who are in fee-for-service Medicare. When a service is covered by fee-for-service Medicare pays the provider the Medicare payment rate, just as it would for any other beneficiary. Historically, most Medicaid programs have paid the Medicare co-insurance. But do to a clarification in the BBA, the state program can opt to pay a portion or none of that coinsurance if their Medicaid rate is lower than the Medicare payment. In other words, states are now required only to fill in the Medicare cost-sharing up to their Medicaid payment rate.

So I'll give you a quick example. You've probably heard this one before if you've gone through this before.

If the Medicare total payment rate is $100 and Medicare pays 80 percent, we pay $80. The remaining coinsurance is $20. If the Medicaid payment rate for that service is $90, Medicaid would pay $10 of that coinsurance to the Medicare provider. If the Medicaid payment rate were $70, and it was stated in their state plan that they would only pay up to the Medicaid rate,

they would pay no coinsurance to the Medicare provider for that service.

In general, beneficiaries cannot be charged for this uncollected cost-sharing, but the impact of this policy is that the providers will not get paid as much for delivering that service to a dual beneficial than most of its other patients that it may see, assuming that they have supplemental coverage that pays for this, and usually it does.

Facility-based providers, however, can offset some of this loss because they can claim it as bad debt and it is reimbursed by Medicare.

Somewhat different rules apply for outpatient mental health services. I think I'll try using a similar example. If the Medicare payment amount is $100, Medicare is only required to pay $50, 50 percent of that. Medicaid, at most, is required to pay only 12.5 percent or $12.50 of that cost-sharing. The beneficiary can be charged for the remaining $37.50. So there are some different rules for that type of service.

For beneficiaries enrolled in M+C plans,

Medicare pays a capitated rate to the health plan, just as it would for any other beneficiary. However, because dual beneficiaries are often sicker than other beneficiaries, the risk adjustment formula produces a higher payment for them.

For certain specialized plans, such as PACE plans, the normal risk adjustment calculation is paired with a frailty adjuster which pays plans a higher rate assuming that most of their beneficiaries have limitations in their activities of daily living.

Medicaid is the secondary payer and, in theory, is responsible for the cost sharing. This doesn't always happen. It's somewhat inconsistent, as some case studies have shown. The issues that are cited in this is often that the plans don't have information that these beneficiaries are dually eligible. They do not even know to go look for that money from Medicaid. We've seen a number of studies point to the fact that states have a hard time getting reliable and timely information to plans.

M+C providers may also not be Medicaid providers and therefore have a difficult time billing

Medicaid for the coinsurance. It's also possible that Medicaid would claim that the M+C plan payment to the provider was sufficient and exceeded the Medicaid rate and therefore they do owe any additional cost-sharing, similar to the fee-for-service provision.

In addition, I wanted to point out that Medicaid is not required to pay Medicare plans premiums and particularly as more plans are charging premiums this ends up being perhaps a more significant issue.

Some states have opted to pay these premiums because the additional coverage the premium buys, say for example outpatient prescription drug coverage, offsets what Medicaid would have had to spend otherwise for this benefit. But in other cases, states do not pay the premiums and beneficiaries are restricted in their enrollment in M+C plans. Plans, if they do not receive their premiums for three consecutive months, are permitted to disenroll the beneficiary.

There are some innovative approaches out there to integrating Medicare and Medicaid financing that address many of these coordination of benefit issues, and perhaps more importantly align incentives and

improve the quality of care that is delivered to this population.

I won't go into detail on these programs now but I just wanted to point them out and note that they serve relatively a small portion of dual beneficiaries. The thing that unifies these programs is that they receive an integrated payment for Medicare and Medicaid serves. Both are capitated payments for each program services. They include PACE, which serves primarily a frail elderly population, has a care model that is very specific. It is a nationwide program but is currently operating in about 14 states. Minnesota and Wisconsin each have state waivers and have had several years of experience now with integrating the payments and service delivery there.

And then other states have launched other programs that just capitate the Medicaid acute and long-term care services and put particular emphasis on coordinating with Medicare benefits. They may have designated people who are designed to work with Medicare providers to facilitate coordination of care.

Let me go on though to the issues and

implications that emerge from these coverage and payment policies. First, we would note that spending for each program is affected by the other program. And as a result there is an incentive for cost shifting between the two programs. For example, I talk about this a little bit more in the paper, if a state Medicaid program is successful in challenging Medicare denial of home health claims, Medicare will pay those claims and spend more money. This will relieve Medicaid from paying those claims and they will save money.

This budgetary tension can also undermine coordination of care. For example, Medicaid programs may not invest in services such as care coordination that reduces hospitalization because the payoff for that investment is accrued to Medicare. They cover the hospitalizations, they will get the savings.

Similarly, at a provider level nursing homes have a financial incentive to hospitalized patients for a three-day stay. So that upon discharge back to the nursing home a Medicare SNF covered stay would be triggered. Medicare payment rates are generally higher than Medicaid and so the Medicare covered stay is

financially preferable. This incentive is tempered by data that's being collected on rehospitalization rates but nevertheless the financial incentive is in place.

These incentives for inefficiency and also the bureaucratic wrangling over who pays for what service likely increase total costs.

Then we just go to the impact of access and note, just following up on our discussion before about the limited cost-sharing provision that limit that amount of payment, some providers may be less inclined to take dual eligible beneficiaries. In fact, CMS did contract for a study that looked into this question in nine states and did find that there was a reduction in utilization that correlated with a reduction in payment. And this was particularly noted for outpatient mental health services.

It is difficult to pinpoint the total impact of this policy at this point. That study looked at nine states. We don't know what's happening in all the states. We don't know how much lower their Medicaid payment rates are. And we don't know for what services they've decided to this for because they can choose to

have different policies for different services.

Access to care could also be threatened on the M+C side to the extent that beneficiaries are avoiding care because they are being charged for it and they actually shouldn't have been charged for it, and the fact that Medicaid is not required to pay the premiums may be a discouragement to these beneficiaries for enrolling in this type of plan. That may be of concern if you feel that this kind of plan would actually benefit these beneficiaries who have a lot of health care needs.

I would also note that recent legislation, DIMA, did have a provision that allowed specialized plans to focus on dual eligible populations, as well as other vulnerable populations. And if they were focusing on them they would be relieved of certain regulatory requirements. And that may enable them to enroll more dual beneficiaries. Of course, we don't know how that will actually play out. And it does seem that it's limited. It doesn't necessarily apply to those M+C plans that are serving a much more diverse population and haven't chosen to just focus on duals.

Lastly, we would note that there has been some inconsistency in the way that conflicts between the two programs rules have been resolved. For example, as Medicaid programs begin mandating enrollment in managed care plans, dual eligibles were exempted from this requirement on the grounds that they were Medicare beneficiaries first, and that as Medicare beneficiaries they had freedom of choice. But as we see in the cost-sharing provisions, that Medicaid payment is now adequate for these beneficiaries. And in that case, it seems that they're Medicaid beneficiaries first, Medicare beneficiaries second.

I think with all those words, that concludes our summary of payment and coverage.

I just would note what our next steps are. I think we have a little bit more work to do on this area and we look forward to getting your comments and out some of the facts and implications. And then we want to move on to the other areas that I mentioned before the demographic characteristics, cost and use of care, and access to care.

We're hoping to get this into shape for a June

report chapter. And we look forward to your comments on the content and tone, and anything we might have missed so far.

MR. DURENBERGER: I'll be brief.

I just want to thank you, Mr. Chairman, and Mark, and obviously both of you for the quality of this work. I think, as I listened to you go through this, it's so much easier to understand than dealing with the aggregates of all of the hospitals in America, and so forth, because we're finally concentrating on looking at this as people.

I laughed as you were going through the presentation and I wish Sheila had been here, because we're the people that are responsible for doing all this sort of thing and creating all of these kinds of things, which only reflects on the critical importance of finding a way to undo it, is much harder. But we can't do that unless we understand what it is. And that's why the importance of this contribution to our work, I think, is enormous.

I was looking at page 10 on the separate payment systems and clearly this does not only apply to

low income dual eligibles. This applies to the whole system, all of this, promotes cost shifting, undermines coordination of care, increases total cost. This whole list is the American health care system. So this is an incredibly valuable insight, certainly for me and hopefully for a lot of others.

One of the things that's a distinction here maybe more than in other places though is the population that's involved. And to that end, when you go back to the beginning of the work product, I'd appreciate it very much if we could spend a little time researching the language that is used. And I put it under information, education, communication.

Any of us who have ever been through the system, either as providers or consumers, understand nothing about the "benefit" or the enrollment. All of this stuff is just totally confusing.

I really think, since we're going into this new Republican world now with HSAs and MAs and all that sort of stuff, and everybody's going to be walking around with money to buy into the system, we really need to focus on how do we communicate what it is that is the

most appropriate benefit, access, all these other issues.

So to that end, and I know this maybe just be another project rather than a project here, anyone who is familiar with that part of the system knows that you cannot put all of this into any kind of a one-pager or a two-pager or anything else that will adequately present a family faced with a particular situation or an individual faced with a new crises with the kind of information they need.

Just this little interchange here about is a home deductible and all that sort of thing, I recall going through this process with mother. She's just living longer than anybody expected. But I got 11 languages to deal with, and that's only on the English side. And then we move on to all of the other languages in my community.

All of the information in the system, including 1-800-Medicare, with on all due respect, is unintelligible to the average American. And so if, in fact, we are moving to getting the consumer, the family, whatever it is, much more involved we really do need to

spend some amount of time helping the policymakers and implementers focus on language and focus on what it is we are trying to present them with in terms of alternatives.

In addition to that, we have to get rid of things like this is not a bill, and all the rest of those things that confuse. But the most important part is language and is communication.

And I would stress that in this population, because across America -- and you know the data better than I would -- but across America, including North Dakota, Minnesota, Montana, places like that, the cultural change in America in just the last 10 years is enormous. And the way in which different people from different backgrounds and different families are confronted with the need to come into this system at the level that we're talking about here, dual eligibles and so forth, is enormous. And the way they think about it, the way the react to information, the way they use that information in a particular community, the way providers have to react to that, is also an enormous challenge.

So I probably haven't put my finger on the

right phrase to use here, but in terms of what is the work effort, if it is possible to put some time into at least outlining the problem for policymakers, I think it would be helpful.

MR. HACKBARTH: I think you're absolutely right about how well or poorly we communicate these things, although in this area in particular I think an important part of the problem is that the underlying policy isn't coherent. So you can spend forever trying to state it clearly and make it sound better, but it's hard to change the underlying reality.

MS. DePARLE: You just made my point. I agree, Senator Durenberger, with everything you said about communication. But whenever I return to the subject, and you did a great job of outlining the issues and the current state of the program, I'm reminded of how crazy it is to have all these different categories, QMB, SLMB, QI, DWI, QDWI, whatever it is.

What does that community to people except a mess with all the different tests? Clearly what makes most sense is if we had a separate thing that was Medicare Plus or Medicare something for people who were

very low income.

I worry that the new DIMA provisions, while well intentioned to help people who have the greatest burden in trying to meet the costs of a new prescription drug benefit, is only going to add to the complication. I don't know whether that's anything that we could ever have an effect on but certainly I think that's a big part of the problem.

MR. DURENBERGER: You're making my point in so does the Chairman. Our message has to be to policymakers that -- because most of these people who are here in this town understand nothing about the policy that they're dealing with, in all reality. There's a few people that understand the difference between a QMB and a SLMB, but most of them don't understand Medicare versus Medicaid.

So they have to be presented with the challenge you faced as the administrator in a different way, in a context which goes back to their district and to the people that come into their offices and complain about language and not understanding this and how come I have to give up my home and things like that.

So I don't disagree that policy is the problem. But I think we have to -- we should play a role in putting a way to educate these policymakers on the consequences and what are the alternatives. Thank you very much.

MS. DePARLE: Yes, and the challenge that I faced as the administrator was not this. I'm not proud of that, but for every one call or letter I ever received about any of these people, there were 500 about which hospital fit into this or that category and wage adjustment.

So we're not talking about -- I think the point that Anne made at the beginning, is we're not talking about 20 percent of our beneficiary population who fall into this category. And whatever the reasons have been before that we haven't focused on it, we have to start focusing on them.

One thing that would help me, Anne, and I don't want to add to your burden in trying to get this done by June, but if there's a way to construct an average -- there probably isn't, but an average dual eligible to sort of give us a little more flavor for

here's what the person might look like. This is the kind of spending they would have. They've been in a nursing home in a given year or whatever.

Because we tend to look at things here in stovepipes of services. This has come up repeatedly over the last year, maybe those are duals. Is that who that is, the high spending people in that category or the ones where the nursing home is having trouble covering them.

It would help me to see that. And maybe even a low end and a high end. I don't know if that's possible but I think that would help me to get a better sense of who these people are.

MS. MUTTI: Absolutely. That was part of our plan in our cost and user of services and also in our demographic analysis, too. And maybe there's an average dual beneficiary out there, but maybe there's not. Maybe it would be helpful also to provide with you're going to see there's three major types of dual beneficiaries and their health care needs actually vary quite a lot from each other. And this is what each of those categories -- if we can do that, that's our goal

because I think it would help tease out what some of the real issues here are, where the access problems are going to be, who specifically would face those, if there are any.

DR. WAKEFIELD: Some of the thoughts that I had in reaction to this chapter have already been expressed.

I'd say when I was reading it, the further I got into the draft the more I started to reflect on, there was some TV program that was something like good pets gone bad. This is like a good program, God love you for creating it, whatever role you had, gone bad. That's just the sense I had.

The complexity here and the disservice and the dissimilarities in a population that is, I think, unarguably the most vulnerable of the population we care about, really starts to come through here. I think most of us would have recognized that in the back of our minds. But you did an exceptional job of beginning to tell the story. So that's my first comment.

And I'd say stay the course because this might be one of places where we as MedPAC could make one of

our best contributions to the extent we can perform -- help first educate and then secondly inform people's thinking about this in order to drive hopefully some meaningful change over time. I can't think of a better cause, personally, than really drilling down in this area.

So you start to do that, at least you did it for me when I was reading this. And I think it's a really good use of our time and resources and so on. So that's the first comment.

The second comment is I don't know that -- for example, it was jarring reading about the mental health coverage and that particular section as an example. I don't know that you would ever have access to or we could find anything that would tell us about whether or not these people just sort of fall off in terms of being able to access services. That is, we know utilization drops but is there anything else that happens? Do we see a bump up someplace else like in emergency room visits or in hospital utilization when those benefits start to slide down? I don't know that we've got data that tells us that. What we know is that there's fewer

utilization, I think it was of inpatient mental health services perhaps, or outpatient it was.

But is there anything else that's happening that might have a cost implication for the program? Let alone what may happen if we're assuming that this isn't overutilization at the front end?

So if we got that, that might be a helpful piece to toss in as well.

Two other comments. One, you do a nice job of highlighting some of the state demo programs and the PACE program. And you pretty much let the reader know these things are not out there and they're having a relatively small impact in terms of the total population covered. I probably might even try and make that point a little bit more firmly, because for example the PACE program as it's currently constructed, it is extremely hard -- although there are efforts being made -- to try and reorient PACE so that it's viable in rural areas. Historically, it has not been.

So when we start to look at the programs that you're dishing up here as alternatives, they're great. But A, to your point, I think the point needs to be made

strongly, not used very much. And in fact, there are some real limitations in terms of where they can be applied. So that's another point that I wouldn't lose in all of this.

Your implications piece here, we're not teeing this up at the level of recommendations at all when this comes out in the June report. But I do think that to the extent that we can put a road map out there in some fashion, your implications start to move us that way, to really say this is what's happening with coordination of care, of quality implications and access implications.

I think, in addition to educating and informing, without going to the level of saying here are the 15 things obviously that need to be done, if we can't go there, to be as clear as possible in helping the reader understand what next steps might be at least worth considering.

So as much effort as possible on the implications side because the problem is so serious, the challenge is so serious that if we can start help people thinking about what might be some viable alternatives and solutions without saying here are the 10 things that

must be done tomorrow, I think that's going to be well worth spending some time, too. Not easy, but well worth spending time. And you've started to do that with your implication section.

So bottom line, really illuminating. I thought the variability that you describe here is jarring on the face of it within the program and I think it's a great piece of work that you've kicked off.

MS. RAPHAEL: There were four points that I just wanted to see emphasized as you move forward. The first is that we actually have 50 Medicaid programs in the United States not one. And I think that really affects a lot of the other issues that we're trying to wrestle with here.

Secondly, I think we need to really interlace this with what we're doing on quality because I think at the consumer level it really does affect quality. I think that this particular group of beneficiaries, because they have greater needs and utilize more services, the fissures and cracks in the system are magnified in their case. And when you look at transitions, the failure to communicate information, the

need to move from one payment to another, I think really is very, very important in terms of what happens on quality.

I know in the long-term care system you could prevent rehospitalization but there's no reward or incentive to prevent rehospitalization. That's just one example of many, many other examples of how incentives are not aligned here at all.

A third issue for me, which you made and I think I'd like to see some examples and really some more emphasis, which is this adds to total cost in the system. You mentioned the Medicare maximization programs. I know we're just one of many, many organizations where we've had groups, the state come in, they want claims going back 11 years to rebill to Medicare and say you have to hire 100 people to go and really do the review of thousands upon thousands of claims. And it adds a lot of costs to the system. And there are many, many instances of one payer trying to shift to the other payer and adding costs and ultimately raising the price that the federal government is paying overall.

Lastly, I would be very interested in seeing if you could pull together something more on managed care because ostensibly this is the group for whom you would want some managed care options. This is a group that really could benefit, whether we call it coordination or managed care, care management.

So I'd like to kind of see right now what is the state of what's happened in managed care, whether it's in M+C or in one of these integrated managed care programs or moving to disease management or chronic care management. And some notion of what we think might be possible in terms of trying to have some real viable managed care options here.

And is it risk-adjustment issues or is it the lack of real clinical models that's impeding work? Or is it ultimately the financing? Because I don't think we're yet laying the groundwork for the next generation of managed care for this particular population.

DR. MILLER: Can I say just one quick thing on your very last point? This is one of the groups that we're going to be talking about in our disease management analysis. So I think some of what you said

on your last point could also be dealt with there. But wherever it falls, it falls.

DR. REISCHAUER: Anne and Sarah, I think you've done a really good job and we've started down the right path here. I've groveled around in this literature a good deal over the last few decades and I learned quit a bit from this.

I initially was being motivated to speak because I wanted to disagree with Nancy Ann when she mentioned the word average. And then Carol came in and said what I was going to say on that score.

I think averages here are dangerous. In fact, they might describe something that doesn't exist both because, as you pointed out, there are different in a sense flavors of Medicaid beneficiaries, full duals, QMBs, SLMBs, et cetera. But also because the state programs vary so tremendously.

The ramifications thereof are less for the elderly than they are for the non-elderly population. But nevertheless they are significant. And I was hoping what you could do is pick a couple of very different

state programs. I think there are some programs that pay quite high to providers and some that pay abysmally low and some that have very rigid eligibility standards or enforce the federal ones, and some that are a little looser and goosier about that. And just sort of give us a flavor for that, rather than the average.

The other thing I was wondering whether it would be possible in the demographic analysis to give a picture for the fully dual eligibles of when and how they come on and how long the stay. I have no idea whether of the fully duals, 80 percent of them come on when they first get Social Security full eligibility at age 65 and stay on until they die, unlike the working population and the Medicaid people. Or whether a very high fraction of them sort of come on as their incomes go down. It's the 75-year-old widow who doesn't get the pension anymore from her spouse who's passed away and whether we're dealing with that sort of person.

If it's the former it really strikes you as crazy that we do this the way we do it because we have these people, in a sense, in our responsibility for a 20 or 30 year period. So to have them handled the way

they're being handled makes no sense.

DR. ROWE: Another category are the ones who are in long-term care facilities and become Medicaid beneficiaries because of the spend-down of their resources. And that is a particular subset that might be particularly interesting to look at with respect to their utilization.

DR. STOWERS: I also thought it was a great chapter.

I wanted to get back a little bit talking access and quality to that copayment issue that you had. I know in my practice our state makes a very strict point to keep below the 80 percent of Medicare payment levels. And I think that's the case in a lot of the states, so physicians are taking care of these individuals at essentially the Medicare rate without the copayment. So that gets to be a problem with access and I think we need to look at access in that group like you're talking.

But in my personal observation the real access problem here becomes in the ones we just talked about in long-term care facilities where the Medicare payment for

taking care of nursing home and long-term care patients is extremely low anyway for physicians. And then we turn around and reduce that payment by another 20 percent. And the number of dual eligibles in our nursing home, we may want to bring up also, is a very large percentage of those patients.

So the majority of the nursing home patients end up getting taken care of for a very discounted rate. And therefore, it's very difficult to find physicians that will get into this kind of care and take care of these people where real coordination of care that was mentioned before is really needed. That goes for home health or anything else where we're trying to take care of those individuals.

So I think that would good in this to get the data somewhere along, and you may already have it, of comparing the Medicare payment rate in the states to what the Medicaid payment rate is. And therefore we can really see what physicians are being paid. Are they getting a copay? Are they not getting the copay by state? And maybe that will answer some of our access problems.

But anyway, good chapter.

MS. MUTTI: We don't have that data right now. We'll look for it and see how we do.

MR. SMITH: Thank you. This was terrific stuff and almost everything that my colleagues have said I agree with. Let me just try to quickly underscore three points.

I thought Dave Durenberger's initial reaction was exactly on target, that this chapter ought to cause those of us who have some responsibility for all of this to say oh my God. As we think about what this chapter's purpose is, we ought to see it in the context of a motivational instrument rather than a technically accurate and descriptive one. That's tricky business for us, but I think Dave and Nancy Ann had that exactly right.

Some of the questions that Bob raises about the demographics of these folks, there are two sets of questions. The take up rates here are low. And is there something important to understand about who accesses this loony movie system and what sort of utilization they are able to therefore make of the

health care apparatus. And the slightly larger number of folks, it seems to me, who are eligible but don't access it, and what do their utilization patterns look like.

And related to that, and it's a question that grows out of Carol's observation and a little bit of the work you've already done on the specialized programs, is there anything, whether it's state Medicaid payment rates or access to one of the specialized programs, PACE or Wisconsin or Minnesota, is there anything that we can look at and say this is associated with higher and more appropriate utilization? That might begin to pave some of what a road map might look at. The kind of road map that Nancy Ann talked about.

The answer may well be no, but as we look at variations in utilization, it might be useful to ask ourselves are there any characteristics here which seem to be systematically associated with better utilization, no matter how complex the apparatus is.

MR. HACKBARTH: Okay, well done. Thank you.

We'll now have a brief public comment period.

MS. SMITH: I'm Alyse Smith with the American

Health Care Association representing skilled nursing facilities.

First of all, I just wanted to express my deepest appreciation for this work that is going to be done on the dual eligibles because, as we have said so very often, because of the great percentage of dual eligibles in nursing homes this truly affects and impacts our ability to provide care.

I just want to mention one thing, and we will supply the MedPAC staff with this information. All across the scene it is as if the left hand does not know what the right hand is doing when it comes to the particulars of some of these programs. For instance, MedPAC staff said that unpaid copayments are covered by Medicare as allowable bad debt.

What has happened at the end of last year is that the Centers for Medicare and Medicaid Services issued a proposed rule proposing a reduction in bad debt allowance of 10 percent in the first year, 10 percent in the second year, 30 percent in the third year, and hen forever after 30 percent to equalize it, so to speak, with the 30 percent on the hospital side that was put in

place by statute.

There was no mention in the proposal rule of dual eligibles. The word Medicaid never surfaced. There was no mention of the percentage of dual eligibles in nursing homes, the percentage of Medicaid patients in nursing homes, and the potential percentage of very high bad debt attributed to unpaid copayments regarding Medicaid patients.

We supplied all of this information to CMS and to their credit, at least to this point, the final rule has been delayed and delayed because I think it is being further scrutinized. I simply raise this because all of these pieces are out there and few people have tried to put them all together in one place.

Thank you very much.

MR. CALMAN: I'm Ed Calman. In General Counsel to the National Association of Long-term Care Hospitals. I have one observation and two comments.

The observation is I really want to tell you what a fine job your staff is doing in their long-term care hospital study. I've been around for awhile. This study is being done with more than ample resources,

appropriate resources, an open mind, and a sincere dedication to getting the right answers. I think you ought to be very proud of them and how they are proceeding.

My two comments are as follows: in the discussion of long-term care hospitals in the public materials there's the statement that long-term care hospitals provide post-acute care services to a number of stable medically complex patients. Patients who are admitted to long-term care hospitals are not necessarily stable. Long-term care hospitals have most of the resources of other hospitals. Patients in long-term care hospitals, they have codes. They have management of medically complex cases that are unstable. The objective is that they become stable so that the wound and the weaning in the same patient can occur.

That's my only comment with respect to the findings that were made today.

I'm impressed and interested in the discussion of dually eligibles because long-term care hospitals have a stake with dually eligibles. I sit at my desk and I get phone calls from various states. The one

that's the worst is Alabama, where there's only five Medicaid days allowed per year. So a dually eligible that's a long stay in a long-term care hospital, and we have them, ends up with zero Medicaid coverage, especially in the states of Alabama, Mississippi, and Texas. It's very unfortunate because the incentive is to drastically underserve these patients.

And I'm familiar with Alabama, all of these patients or most of them end up in one state hospital that's run by the University of Southern Alabama. And then they bounce from nursing homes to hospitals. If a study was done on their morbidity, I think they would be true victims of this Medicaid eligibility system.

When we had the Catastrophic Coverage Act of 1988, the one thing it did that was not controversial was do away with the Medicaid day limit. And it did not cost much. I remember I was looking at the CBO cost of that, it was scored separately. And that brought a uniform standard of care to all these patients across the nation for hospital care. And it was a real shame that it was repealed because that was a great leap backwards for these cases. And if a study was done, I

would assume that morbidity went up because of that action by Congress.

At any rate, thank you very much for your inquiry into these areas.

MR. FENNIGER: Randy Fenniger, Federated Ambulatory Surgery Association. I have what I trust will be very brief comments on the recommendations that have been considered and voted on.

First, on payment advocacy, we've expressed this before and continue to be concerned that since there is no data, the Commission falls back on the use of proxies which we think are not an accurate reflection of whether reimbursement for a given set of procedures is adequate or not.

You're looking at an ASC system that has evolved into what it is in terms of Medicare, not what it might be. There are some 2300 covered procedures, many of which are not done with any great number in the ASC. I would wonder are those rates, in fact, adequate, inadequate, why are they not being done in the ambulatory surgery center when they are being done in the hospital outpatient department?

So I think that the lack of data is a handicap. We urge a great deal of caution in your evaluation of how well we are or are not doing based on the proxies that you've established to date.

I would only make an observation here, in dealing with urologists, who have started to move into the ambulatory surgery center arena in small numbers, not compared to ophthalmology or GI. The primary reason is not the rates. They all complain about the rates at the ASC level. It is the efficiency of the model. They can do twice as much work in the ASC as they can in any hospital in America. And so it is a quality of life, it is an efficiency of practice that motivates them.

And I think as you consider adequacy of rates and some of the other issues that came up in discussion, you have to look at all of the motivations for the development of these centers.

Your second recommendation, which you voted on, I do not understand the discussion around capping the ASC rate at the HOPD rate whether or not it's determined the ASC cost is higher than the HOPD rate. if it is higher, pay it. If it's not, pay it at the

rate at the cost that it exists. But to simply say this is the cap, you've got to live with it no matter what we learn, seems to me a rather arbitrary decision to make, inconsistent with the idea that was expressed in part of the discussion that what we want to do is try to figure out what the costs are and then make sure we pay our fair share of those costs.

So I would encourage you to move away from that kind of arbitrary cap idea and deal with the numbers as the numbers ultimately come out, if they ever do come out.

The collection of data to constantly or continually evaluate and update a new payment system, the existing payment system, any payment system, is theoretically a wonderful and necessary idea. In the ASC industry history works against us. Unfortunately, the Department has a very poor track record, as has been discussed here many times, in the collection of data about ASC costs and activities.

We're very concerned that if your recommendation goes forward and, in fact, gets incorporated in whatever new payment system comes out,

that we will be again held hostage to the unwillingness and/or inability of the Department to collect this information.

I don't have an answer to that but I hope that you will consider this very carefully as you go forward because part of the reason that these issues have been brought to your attention has been problems with data collection and updating the system in the past. Please don't put is in that box again by another recommendation. We would welcome your advice to not only us but to the Department of how to get around this problem so we don't relive this particular situation.

Recommendation number three, the comment on the development essentially of a new coverage process for ASC procedures being done either simultaneously or after the completion of the payment system, I would argue strongly there is no reason the Department could not work on the development of new coverage standards. They have done some work going back to '98 which was published, never adopted.

I can certainly understand not introducing that until you've introduced a new payment system. That

would be chaotic. But we think that it makes very little sense to introduce a payment system and not at the same time come in with new coverage rules. So we would ask that you consider that aspect of that timing so that both come out at the same time.

Again, being very concerned that if they issue the payment system, they haven't looked at the coverage rules, my grandchildren will have grandchildren by the time we see new coverage rules, just based on history.

You dropped the issue of the physician office. We thank you for that. I would only note that the practice expense portion of the physician payment is calculated differently than all other costs in the HOPD or the ASC. You're going to have to grapple with that issue when you come back to it.

I would also note that anything a doctor does in his or her office they can do in the outpatient department of the hospital. There's no limitation. Why would you put an arbitrary limitation on their going to the ASC with they can go to the HOPD. I just don't understand that.

Deja vu all over again, self-referral. Just a

few comments if I may, without trying to grind my teeth because I've been through this so many times.

When Stark was debated, the specific issue of the ASC ownership was debated. They were dropped from the legislative consideration, the reason being the ASC was seen as the extension of the practice. The physician refers and then goes to perform the service himself or herself, a vastly different scenario than referring to a laboratory radiology center in which you have ownership interest, benefit from the referral, but do no work yourself. I think that distinction holds. We would certainly argue that in a 30 year history of ASCs there's no evidence of overutilization.

I do know that when the Florida people, back in the early '80s, looked at these issues, they did examine ASCs in Florida, found no problem worthy of raising, although they did find problems in laboratory and radiology which ultimately became the basis of much of the legislative consideration.

Interestingly, the safe harbor for ASCs requires owners to do a certain amount of their practice in the ASC, thus forcing volume into the ASC if you were

an investor. So one part of the law is saying you've got to do it there. And so when you think of self-referral issues, you have to keep that in mind.

I am struck by the issue of conflict of ownership of an ASC by a physician. I don't see that that is any different, if there is a conflict at all, than ownership of a physician by a hospital. If we can't own things, they shouldn't be able to own people because they own practices and employ physicians. And I think if there is a potential for conflict and abuse, it can exist in any of those settings. Frankly, I don't think it does exist, but I think the potential is there and they should be evaluated equally.

Finally, the movement from the hospital, which I know you will be talking about in other guises, I would give you one anecdotal situation. Why do procedures move out of hospitals and into other settings?

Empire Blue Cross-Blue Shield, some of you, perhaps Dr. Rowe is very familiar with them as an insurance company, sent a letter to gastroenterologists in their coverage area who practice at hospitals, mostly

teaching hospitals in New York and Long Island, saying we're dropping you from our plan. Why? You do too many endoscopies in the hospital. So go do them somewhere else if you want to stay in our plan. Do them in your office or do them in an ASC. A particular hammer on a teaching institution.

But here you had a private insurance company, the largest private carrier in the New York metro area, saying we want you out of the hospital. We won't pay you. We won't send you patients. We won't pay our enrollees if they see you.

So there are a lot of things going on to move things out of the hospital and into other settings other than perhaps income aspirations of some owners or investors. I'd simply ask you to keep that in mind and investigate that very carefully as you move into this, not only with the ASCs but the specialty hospitals. And I'll be back for that one, too.

Thank you.

MR. MAY: Don May from the American Hospital Association. I just want to make a couple brief comments.

I really appreciate all of the discussion that you had here today. The insights and perspectives that you all bring to the various subjects are very enlightening and helpful to us to hear all the different perspective.

Two things. One is on the dual eligible discussion. It becomes pretty obvious that our health care system, if you want to call it a system, is pretty broken. It's broken at how we provide care and how we pay for care. And it really raises some fundamental questions about how do we change how we do this versus tweaking it and all the little pieces that we do on an annual basis in all the different programs we have.

But I guess we do have to tweak. And so for the tweaks, let me just raise my second point on the outpatient outliers issue. We definitely agree that there's a problem in how outliers are currently paid in the outpatient system. And I think the real problem here is not that outliers aren't necessary in the outpatient PPS, but that the unit at which they're paid is too small, which frustrates us all when an x-ray seems to be the most reimbursed item in the outpatient

PPS outlier system.

I would offer two thoughts there. One is we definitely need to increase the bundle and look at how we pay the outliers.

The second thing is I think it's based on the fundamental flaw of the outpatient system that it's underfunded. You've set an average payment for outpatient and an averaging system where the average payment is well below the average cost and it makes it very difficult for an averaging system to work when that average payment is set well below the average cost of care.

We were somewhat concerned today when we didn't see some of the other options that were discussed last month around raising a threshold, at looking at expanding a bundle. And I think that had some different analysis been done to show if you change how you pay outliers, it may have driven some results that may have been more in line with what I think people were frustrated that they didn't see, that outliers were going to the most expensive cases. Which is really what we care about, is covering the most costly cases, either

the new procedures that are first moving out of the inpatient setting into the outpatient setting, or that happens to be the train wreck case that really does cost an exorbitant amount of resources.

We still believe that they are very important, especially since the outpatient system is still very volatile with changes in payments from year-to-year at the APC level, and in particular losing the transitional corridor payments that go away beginning this January. The extra protections that were in those payments are now gone for the hospitals who are doing some of the most costly procedures. And we really do believe that those are necessary.

Thanks again.

MR. HACKBARTH: Okay, we are adjourned. Thank you.

[Whereupon, at 12:07 p.m., the meeting was adjourned.]