

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Thursday, December 8, 2005, 9:51 a.m. *

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
FRANCIS J. CROSSON, M.D.
AUTRY O.V. DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

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1 PROCEEDINGS

2 MR. HACKBARTH: Okay, we're going to get
3 started. We are going to begin with a discussion of the
4 mandated report on payment for oncology services.

5 But before we delve into that, we have a large
6 number of for presentations over the next two days directed
7 at assessment of payment adequacy and ultimately moving
8 towards update recommendations.

9 Let me just say a word or two about that process.
10 We take our final votes on update recommendations in January
11 for inclusion in the March report. Today and tomorrow we
12 will have presentations from the staff that include draft
13 recommendations on update factors for various sectors.
14 Those draft recommendations, for the most part -- and there
15 are a couple of exceptions which I will come back to in a
16 second -- but for the most part they simply represent what
17 we recommended last year for that particular sector.

18 So I urge people in the audience to look at them
19 in that context and not read it too much into them in terms
20 of what they may mean for what the Commission ultimately
21 recommends in January.

22 There are exceptions to that. There are a couple

1 sectors that are new for us. This is the first time we will
2 be making update recommendations, and those are long-term
3 care hospitals and inpatient rehabilitation facilities. So
4 there the draft recommendations are not simply last year's
5 recommendation. That's new.

6 And then there is one area, the physician update,
7 where in fact there will be no draft recommendation. We are
8 in an unusual position there in the sense that there's still
9 uncertainty about what the update would be for 2006, and
10 here for our March report we are trying to recommend an
11 update for 2007 and we don't even know the base that we'd be
12 working from, which complicates the task. So there will not
13 be a draft recommendation at this point on the physician
14 update.

15 As always, we will have our public comment period
16 at the end of the morning and afternoon sessions. Those are
17 more widely used during the update season, so let me in
18 advance talk a little bit about the ground rules there.

19 We urge people to talk only about the issues that
20 were brought up in that session, as opposed to some they
21 anticipate will come up tomorrow. So let's keep it focused
22 session by session. And because of the higher demand that

1 we have in this update season we really need people to keep
2 their comments brief and focused and need to avoid
3 repetitive comments. I will repeat those ground rules at
4 the break.

5 I think those are the basic points. Okay, let's
6 then proceed with the presentations beginning with oncology.

7 DR. SOKOLOVSKY: Today I am bringing before you
8 for the final time the Congressionally-mandated report on
9 oncology services provided to Medicare beneficiaries. At
10 this meeting I will present three draft recommendations for
11 your consideration. An additional recommendation calling
12 for the Secretary to conduct a study on acquisition costs
13 for Part B drugs in 2006 has been eliminated because the IG
14 already listed this study in their work plan.

15 I just want to briefly remind you of our mandate.
16 This study is the first of two Congressionally-mandated
17 reports on the effects of changes in Medicare payment rates
18 for Part B drugs. Next year we will look at other
19 specialties that provide many physician-administered drugs
20 and have been affected by the payment changes. We will have
21 an additional chance at that time to examine the workings of
22 the new drug payment system.

1 I won't repeat all of the findings I presented to
2 you in the last few months. The key finding, again, is that
3 Medicare beneficiaries continue to have access to
4 chemotherapy services, oncology practices continue to treat
5 Medicare beneficiaries, and patterns of care remain largely
6 the same. Neither beneficiaries nor physicians reported any
7 change in quality of care.

8 However, going back to at least 2004, some
9 practices were sending beneficiaries without supplemental
10 insurance to hospital outpatient departments for
11 chemotherapy administration. The Congressional mandate asks
12 us about payment adequacy and I will comment on our ability
13 to judge that later when I talk about the oncology
14 demonstration projects.

15 One of the new payment systems for Part B drugs
16 scheduled to begin in 2006 is the competitive acquisition
17 program or CAP. CAP rules require that drugs be delivered
18 to the facility in which they will be administered.

19 Oncologists in rural areas point out that they
20 will not be able to participate in the CAP program because
21 of this rule. Beneficiaries in rural areas tend to receive
22 chemotherapy in satellite clinics. A group practice in a

1 central area provides chemotherapy once or twice a week at a
2 small satellite clinic that's either owned by the physicians
3 or in cooperation with a local hospital. Sometimes nurses
4 have to mix the drugs at the main facility and take the
5 drugs with them to the clinic because the clinic doesn't
6 have the expensive equipment necessary to mix the drugs
7 safely.

8 This leads to our first draft recommendation. The
9 Secretary should allow an exception to the CAP delivery
10 rules for satellite offices of rural providers.

11 Oncologists, again, in rural areas provide
12 chemotherapy through these offices. If they can receive
13 chemotherapy drugs in their main offices they will have the
14 option of participating in the CAP program.

15 The spending implications are negligible, but it
16 would help preserve access for beneficiaries in rural areas
17 and allow rural providers to participate in the CAP program.

18 Last month we discussed the quality of life
19 demonstration project initiated by CMS for 2005. CMS has
20 developed a new demonstration project for 2006. These
21 demonstration projects make it hard for MedPAC to evaluate
22 the full effects of the MMA-mandated changes on the adequacy

1 of physician payments.

2 In the 2006 final rule CMS announced a new
3 demonstration project. Practices must report on the reason
4 for the patient visit, the patient's condition, and their
5 use of clinical guidelines to treat the patient at that
6 particular visit. Reporting will be through newly-
7 established codes and payments would be tied to level 2 and
8 above E&M visits by beneficiaries with one of 13 different
9 cancers. Only hematologists and medical oncologists are
10 eligible to participate. Payment will be \$23 and
11 beneficiaries will still be charged copayments. CMS
12 estimates this project will cost \$150 million.

13 That leads to draft recommendation two. The
14 Secretary should use his demonstration authority to test
15 innovations in the delivery and quality of health care.
16 Demonstrations should not be used solely to increase
17 payments.

18 Medicare demonstration projects are designed to
19 test innovative strategies for improving delivery and
20 quality of care for beneficiaries without increasing program
21 spending. To test innovations, CMS must design projects
22 according to accepted research standards. These standards

1 include a strategy for evaluation. Most researchers do not
2 believe that the 2005 quality of life demonstration program
3 can be evaluated and it is hard to see how the data
4 generated can provide useful research findings.

5 The Congress again asked us to assess payment
6 adequacy. Our analysis found that increased utilization and
7 no sign of access problems, but we can't really tell if
8 payment is adequate. MedPAC and the Congress's ability to
9 assess the impact of payment changes for oncology drugs and
10 drug administration services have been affected by the two
11 oncology demonstration projects. These projects are not
12 budget neutral. They are designed to increase payments to
13 specific specialties.

14 In general, MedPAC finds that if the payment rates
15 are not accurate CMS or the Congress should address the
16 issue with Medicare payment policies. It should not make
17 payment policy through the creation of demonstration
18 projects.

19 This recommendation has no standing implications,
20 but focusing programs' resources on projects designed to
21 improve quality of care and care delivery should benefit
22 beneficiaries and providers in the long run.

1 Erythroid growth factors are used to treat anemia,
2 a very common side effect of chemotherapy. Erythropoietin
3 has long been the drug that Medicare spends the most money
4 on. Since a new product came on the market in 2002 use has
5 increased very rapidly. Expenditures by oncologists for
6 this product increased 33 percent from 2001 to 2002, and 51
7 percent from 2002 to 2003.

8 At the same time, safety questions have been
9 raised about potential overuse and underuse of the products.
10 ASCO has developed clinical guideline guidelines for its use
11 and in 2004 the FDA changed label requirements to ensure
12 safe use.

13 The ASCO quality project that we talked about last
14 month found wide variation among practices in their
15 adherence to clinical guidelines in the use of these growth
16 factors. Guidelines set a target hemoglobin level for
17 cancer patients and say the product should be withheld if
18 the hemoglobin level exceeds that level.

19 Some local carriers have attempted to apply these
20 guidelines, but they are hampered by lack of easy access to
21 necessary clinical data. In the case of dialysis patients
22 who also use these growth factors, providers must enter

1 hematocrit levels on the claim form. Last month CMS issued
2 a national policy for the use of growth factor for ESRD
3 patients based on these clinical guidelines.

4 So draft recommendation three is that the
5 Secretary should require providers to enter patients'
6 hemoglobin level on all claims for erythroid growth factor.
7 The data should be used as part of Medicare's pay-for-
8 performance initiative. Measuring appropriate use of
9 erythroid growth factor meets many of the MedPAC criteria
10 for quality measures. Accepted guidelines exist, the
11 initial ASCO study showed variation in the use of the
12 product and suggested room for improvement. Use of the
13 growth sector is crosscutting, appropriate for many,
14 although not all types of cancers, and practices can provide
15 hemoglobin levels on Medicare claims with minimal additional
16 burden.

17 There are no scoreable spending implications for
18 this recommendation but there could be some program savings
19 if carriers detect over or inappropriate use of the product
20 and reject some claims. It could increase the quality of
21 care for beneficiaries and, again, would create minimal
22 additional provider burden.

1 That's the end of my presentation.

2 MR. SMITH: Joan, thank you. As usual, both the
3 written material that we received and the presentation were
4 clear and useful.

5 Glenn, I don't understand why the implications of
6 the rationale that Joan recited and appear on page 44 of
7 what we got in the mail, why they don't lead to a
8 recommendation that says, the Secretary should cancel the
9 2006 demonstration because it doesn't --

10 This is obviously not a big deal in quantitative
11 terms, but it is a case where without any argument that
12 beneficiaries are better off, we're increasing beneficiaries
13 copays. We're spending another \$150 million of taxpayer
14 money, and we argue, and I think convincingly and the
15 discussion last month was even more convincing, that there's
16 no value from this demonstration. It is designed to
17 accomplish something else. That we should recommend, for
18 the reasons that were clearly articulated, that the
19 demonstration be canceled.

20 MR. HACKBARTH: Anybody want to react to that?

21 MS. HANSEN: I actually wasn't going to bring up
22 the whole thing of canceling, per se, but the whole issue of

1 copays, bringing on the whole question of validity of the
2 study to begin with. So one of the possible questions that
3 would come out from this is the 2006 cancellation itself.
4 But to have beneficiaries copay on something that has
5 questionable value is a question I would bring up.

6 MR. HACKBARTH: Anybody else want to react to
7 Dave's proposal?

8 From my perspective, Dave, I think it is a
9 different thing to say this should have never been done in
10 the first place. To say that in the midst of it, we're
11 going to yank it away with the potential for disruption of
12 the system, I think those are different propositions. I
13 wish they hadn't done it in the first place but,
14 nevertheless, I would be reticent about saying, it's out
15 there and we're going to yank it out at this point. But I'm
16 open to other comments.

17 MR. SMITH: If the disruption issue is a real one,
18 Glenn -- I don't have a good way of assessing the potential
19 for disruption, but I do know that we think we're not going
20 to learn anything, and the Secretary is not going to learn
21 anything, and that beneficiaries aren't going to be better
22 off and that they're going to pay more.

1 DR. MILLER: Just a couple of other reactions.
2 The estimated \$150 million and it not being significant.
3 One thing to frame in your mind is the difference between
4 the amount of dollars that move out through drugs, which is
5 a significant payment, and the amount of dollars that move
6 out through administration. I think it is a question of how
7 significant is this is.

8 The real frustration on the analytical side of
9 things, and Joan I think is just being polite, is that we've
10 been asked to evaluate the impact of these changes. Of
11 course this was stuck into the middle of the changes so the
12 ability to evaluate them -- and this is really just Glenn's
13 point -- is we can't quite figure out whether this money is
14 needed or not because they didn't let the payment changes go
15 into effect. I think that's the rock we find ourselves on.

16 DR. REISCHAUER: I agree with Dave's point that
17 this is a faux demonstration and inflicts costs on
18 beneficiaries for which no benefit accrues. But by the time
19 our report comes out this will be a month and-a-half down
20 the road and I think the real issue is whether we should
21 provide guidance for 2007, which is what this report is all
22 about, and say something about ensuring that payments are

1 adequate so you don't have to phony them up with a
2 demonstration, and be more explicit in the text about that,
3 because we had the same feeling the last go round on this
4 demonstration. So what happened? It was transformed into
5 an equally invalid demonstration.

6 MR. HACKBARTH: The ultimate question for this
7 study was would this quite significant change in how
8 Medicare pays for drugs affect access to care, quality of
9 care and as Mark said, the demonstration helped assure that
10 we couldn't answer that question. So ultimately the
11 question for 2007 is, we need a payment system that does
12 assure access to quality care for oncology patients, but we
13 still don't know what the right level is. At some point it
14 seems like they're going to have to let the payment change
15 go into effect without ameliorating its effect with
16 demonstration dollars and monitor what happens.

17 I don't know how else you're going to answer the
18 question.

19 DR. NELSON: Within the text, it makes the point
20 that they've substantially changed the nature of the demo in
21 2006. So our evaluation was based on an earlier model.
22 What they are proposing has implications of pay-for-

1 performance.

2 The other point is that the expenditures are going
3 to go up to \$200 million in 2005 and who knows what in 2006.
4 But I think that for us to recommend pulling the plug when
5 plans are in the works to substantially change it might be
6 premature.

7 MR. HACKBARTH: Joan, could you just address a
8 point that Alan made? Initially, our recommendation here
9 was based on the first iteration of the demonstration. It
10 has been modified. Is the second iteration -- I'm searching
11 for a polite word -- more credible than the first?

12 DR. SOKOLOVSKY: I believe it is more credible, in
13 the sense that there are three elements to it. One of the
14 elements is to have an indication of the stage -- more than
15 the stage, the condition of the patient. A second element
16 is why did the patient go to the physician for this visit.
17 The third element is the clinical guidelines, which it's not
18 a yes or no question. It's a kind of okay, this patient
19 came and I ordered a CAT scan for this patient with colon
20 cancer at this particular stage now.

21 Then the question is, the clinical guidelines say
22 you should have a CAT scan X number of times. Am I

1 following that guideline? If not, why? Is it because the
2 guidelines are not acceptable? They aren't keeping up with
3 the track. I don't believe in it. My patient is in a
4 clinical trial.

5 I have some questions about the extent to which
6 these will be coded correctly. I think they will take a lot
7 of effort to code. But I think the first two elements of
8 the issue of the condition of the patient and the purpose of
9 the visit, when those are linked back to the A and B claims,
10 will give us -- this is not demonstrating anything but it
11 will give us far more information on the treatment of cancer
12 patients in this country than anything that we have now.

13 What I was told by the people who set up this
14 demonstration project is, their feeling is that they will be
15 able to use these treatment patterns to develop a pay-for-
16 performance system for oncologists that would be very
17 difficult to do at the current state of knowledge.

18 MR. HACKBARTH: So that's also relevant for
19 answering your initial question about whether we ought to
20 recommend simply pulling the plug.

21 DR. KANE: I wanted to bring up a topic that we
22 talked about last time and I think Joan did a nice job. You

1 did elaborate a bit on the people without Part B
2 supplemental coverage, but I still feel we left that to some
3 kind of long-term larger issue around Part B and the
4 potential need for caps on copays. Whereas, this seems a
5 little more to me, this particular population of people
6 needing chemo who don't have Part B supplemental have been
7 definitely put at greater risk by reducing the drug payments
8 and the physicians' willingness to subsidize their
9 copayments. And then, therefore, transferring them to
10 hospital outpatient departments.

11 I would just be more comfortable if either we --
12 we say basically, beneficiary access hasn't changed but I'm
13 not sure that is true, particularly for the Part B people
14 without coverage because they are much greater financial
15 obligations and potentially are not going for their care
16 because of that.

17 I just feel we might want to make a recommendation
18 that this issue needs to be studied in a little more urgent
19 way than some kind of long-term study under general Part B
20 copay limits because I feel these people are really making
21 life or death decisions because they can't afford --
22 potentially, because they can't afford to meet the copay

1 requirements, and they're being put in a more expensive
2 setting where the copays are more expensive. I feel like we
3 just shouldn't say access is fine and hasn't changed because
4 of this change in payment.

5 DR. MILLER: The only thing I would just look to
6 qualify there, I think our site visit suggested that by and
7 large what happens here is the person is moved to the
8 hospital, and you're correct that the copayment liability
9 becomes bigger, but since they aren't able to pay it what it
10 turns into is a program cost by way of bad debt for the
11 hospital. I don't know so much that -- we did see examples
12 where people were saying, given this, I won't get treatment.
13 But by and large, it was people moving to the hospital. I
14 just want to be sure I have that right.

15 DR. KANE: You're looking at a very small sample
16 size. Anybody saying, I won't get treatment is a pretty sad
17 thought. And you're looking at very small sample sizes, so
18 I don't think you can generalize and say, access is not
19 compromised based on -- if anybody is saying, it's not
20 affordable for me, you can be sure there are people --

21 MR. HACKBARTH: That's a broader point I don't
22 think we can overemphasize, and that is that this whole

1 project by necessity, given time and resource availability,
2 is based on site visits to five communities. So we're not
3 talking about a comprehensive look at what's happening to
4 all oncology patients and all locations. This particular
5 finding, as I recall, was specific to two of the five
6 communities where at least there was some report of -- in
7 the case of patients without supplemental coverage being
8 referred more frequently to hospital outpatient departments.

9 Is that right, Joan?

10 DR. SOKOLOVSKY: I think the general access issue
11 and the fact that there is an increasing number of
12 beneficiaries receiving chemotherapy in physician offices is
13 based on claims data. But when it comes to looking at
14 beneficiaries without supplemental insurance, the claims
15 data won't tell us that so it is based on these much more
16 anecdotal site visits.

17 DR. WOLTER: My questions were really language
18 questions in draft recommendation one and two. In draft
19 recommendation one my question is, if you have an urban
20 oncology program that's delivering care in a rural
21 satellite, is that covered by this recommendation? Because
22 of the way it's worded, rules for satellite offices of rural

1 providers. I assume the intention is that if someone is out
2 in a rural area there would be coverage. So we might want
3 to clarify that.

4 Then in draft recommendation two, I read the tenor
5 of the chapter and the tenor of our discussion as, we would
6 not want demonstrations to solely or partially increase
7 payments. So I'm wondering if it would be better language
8 just to say, demonstrations should not be used as a
9 mechanism to increase payments. It's a minor point. I
10 don't know if it really matters, but we probably wouldn't
11 want them solely or partially to increase payments.

12 DR. CROSSON: I think I'd like to underscore what
13 Nancy said. Last year, when we looked at benefit design in
14 the MA program we called out for special attention to
15 vulnerability of cancer patients on oncology medications.
16 It seems to me that doing that in this setting might also be
17 appropriate also. So if we could have stronger language in
18 the text just calling out that issue.

19 MR. HACKBARTH: Any others?

20 We need to vote on these recommendations. This
21 report is due at the beginning of January; is that right,
22 Joan?

1 DR. SOKOLOVSKY: January 1.

2 MR. HACKBARTH: So this is our final look at this.

3 So what we will do, in keeping with Nick's suggestion, is
4 move rural in front of satellite in recommendation one so it
5 would read, the Secretary should allow an exception to the
6 CAP delivery rules for rural satellite offices of providers.

7 Does that address your issue?

8 All opposed to recommendation one?

9 All in favor?

10 Abstentions?

11 Then in the draft recommendation two Nick was
12 suggesting drop solely. So it should read, demonstrations
13 should not be used to increase payments?

14 DR. MILLER: As a mechanism.

15 MR. HACKBARTH: As a mechanism to increase
16 payments.

17 With that change in the wording, all opposed to
18 recommendation two?

19 Is your hand up?

20 MR. SMITH: Yes, weakly.

21 MR. HACKBARTH: Okay, it will be noted in the back
22 of the report as a no with an asterisk, I guess.

1 All in favor of recommendation two?

2 Abstentions?

3 Then draft recommendation three, I think the
4 language on this one stands as is.

5 All opposed to number three?

6 All in favor?

7 Abstentions?

8 Okay, thank you, Joan. Good work on this project.

9 MR. SMITH: I should change my vote. I don't
10 agree with the recommendation. I would prefer a better one,
11 but that's no reason to vote no. I will vote yes.

12 MR. HACKBARTH: It will be so recorded.

13 Next is assessment of payment adequacy for
14 hospitals. You may proceed when ready, gentlemen.

15 MR. ASHBY: Good morning. In this session we'll
16 address payment adequacy for hospitals. We will be
17 presenting draft update recommendations for both inpatient
18 and outpatient services, although you will remember that we
19 assess the adequacy of current payments for the hospital as
20 a whole. Our session will conclude with a draft
21 recommendation on an alternative to outpatient hold harmless
22 payments.

1 I'd like to begin by briefly reviewing our
2 findings from the November meeting. First, we have seen a
3 net increase in the number of hospitals as well as an
4 increase in hospital service capacity over the last several
5 years. By the way, someone asked at the last meeting about
6 the status of critical access hospital applications. The
7 answer is that we now have 1,170 CAHs with just 20 to 30
8 applications still left in the pipeline.

9 Then we found that volume is increasing with
10 especially strong growth on the outpatient side. That
11 quality of care results are mixed with mortality and presses
12 measures generally improving, but mixed outcomes for patient
13 safety. And finally that access to capital is good.

14 Our first chart presents Medicare margins data
15 through 2004. The overall Medicare margin dropped from
16 minus 1.4 percent in 2003 to minus 3 percent in 2004.
17 You'll notice that the drop was somewhat larger on the
18 inpatient side than the outpatient side. This is partially
19 because inpatient cost growth is higher, as Jeff will detail
20 in a moment, but another major factor was a substantial drop
21 in outlier payments for inpatient services. CMS implemented
22 outlier payment reforms in 2003, but they overshot the mark,

1 going from substantially overpaying on outliers in 2003 to
2 somewhat underpaying in 2004. So given that MMA provisions
3 increasing both inpatient and outpatient payments kicked in
4 in 2004, this drop in outlier payments, along with high cost
5 growth, appears to explain most of the decline in margins.

6 Next we turn to our margin projection for 2006.

7 I'll take a moment to stress first that some extensive
8 modeling lies behind this one number and much of that
9 modeling was done by Tim Greene and Julian Pettengill who
10 are not up here and we appreciate their efforts.

11 The two-year projection accounts for a wide range
12 of update factors and other policy changes that affect the
13 distribution of payments, the level of payments, or both.
14 That is for inpatient and outpatient services as well as
15 hospital-based post-acute care and GME payments. In
16 forecasting the increase in costs we use recent data on
17 actual cost growth, going both from 2004 to 2005 and from
18 2005 to 2006.

19 On the payment side, we have to remember that
20 payment increases come not only from updates and payment
21 policy changes, which we've accommodated in our modeling,
22 but also from changes in case mix. In forecasting payments

1 we made conservative estimates of the growth in case mix for
2 both inpatient and outpatient payments, assuming smaller
3 increases than actually occurred over the last three years.

4 As you see, our estimate is a margin of minus 2
5 percent for 2006. The 2006 projection is affected by policy
6 changes both increasing and decreasing payments. Once
7 again, as in the 2004 figure, one of the most critical
8 factors for 2006 is outlier payments. Our modeling assumes
9 that outlier payments will be restored to their target
10 level, which CMS is attempting to do, and that factor is
11 responsible for much of the projected improvement.

12 The gap in margins between urban and rural
13 hospitals narrows in 2006 from about two percentage points
14 to about one percentage point. This is largely due to MMA
15 provisions targeted towards helping rural hospitals, and
16 these are inpatient payment provisions.

17 Now Jeff will provide some more information on
18 hospital cost growth.

19 DR. STENSLAND: The drop in margins that Jack just
20 discussed has in part been driven by increasing inpatient
21 costs. These costs have risen by roughly 6 percent in 2003
22 and in 2004. In contrast, outpatient costs have only grown

1 at roughly 1 percent per year. The natural question is, why
2 is there a difference?

3 There's at least two reasons for this. First, we
4 found physicians are ordering more services during every day
5 a patient visits the outpatient department, a 2.8 percent
6 increase in services per day from 2003 to 2004. These
7 additional services per visit can result in lower costs per
8 unit of service.

9 For example, assume a physician orders a pelvic CT
10 and an abdominal CT on a single patient. Performing these
11 two scans is expected to be less expensive than performing a
12 pelvic CT on one patient and an abdominal CT on a second
13 patient.

14 Additional services per patient creates economies
15 of scale and reduces hospitals' average cost per service.
16 In addition, hospitals face competition from ambulatory
17 surgery centers and physician offices for outpatient
18 services. This competition may put pressure on them to
19 constrain their costs.

20 To arrive at the projected margins Jack discussed
21 we need to estimate how fast hospital costs will grow over
22 the next couple years. In 2004, the weighted average cost

1 growth for inpatient, outpatient and other hospital services
2 was 4.5 percent. We have two pieces of information
3 suggesting that we will see a similar rate of cost growth in
4 2005.

5 First, 580 hospitals surveyed by MedPAC and CMS
6 reported that they experienced an average of 4 percent cost
7 growth for the year ending June 30, 2005. In addition, an
8 examination of recent financial reports from the three
9 largest for-profit hospital chains shows that on average
10 these hospitals had a 5 percent annual rate of cost growth
11 through September 30 of this year.

12 Given these two pieces of information, the 4
13 percent cost growth and the 5 percent cost growth, we feel
14 that an assumption that costs will continue to grow at a 4.5
15 percent rate in 2005 and 2006 is reasonable. Of course,
16 this raises the question of how have hospitals been able to
17 afford this continual rapid rate of cost growth.

18 As you remember from our presentation last year,
19 we noted that private payers have been rapidly increasing
20 their payment rates hospitals. This trend has continued
21 into 2004. We also showed you last year that in periods
22 when profits on privately-insured patients are high hospital

1 costs tend to rise faster than the market basket. In the
2 prior slide we saw the private payer payment-to-cost ratios
3 were high in the 2002 to 2004 time period, and in this slide
4 we see that that the cost growth has been high during these
5 same years. While the 2002 spike in cost growth may have
6 been partially due to the nursing shortage, having four
7 straight years of cost growth above the market basket
8 appears to also be related to the lack of financial pressure
9 from the private sector.

10 The survey I just mentioned, the survey we
11 conducted this year of 580 hospitals, suggests that
12 hospitals' revenue per discharge continues to grow in 2005,
13 though there is an indication that the rate of growth in
14 revenue per adjusted discharge has started to slow slightly.
15 If we do see lower rates of revenue growth in hospitals we
16 may eventually start to see lower rates of cost growth in
17 these same hospitals.

18 Now Craig is going to talk about the interaction
19 between hospital cost growth and hospitals' Medicare
20 margins.

21 MR. LISK: We're next going to go on and report
22 our findings from an analysis of hospitals with consistently

1 negative Medicare margins. If you recall, we included an
2 analysis of hospitals with consistently negative margins in
3 at last year's March report. The analysis I'm about to
4 present to you this morning updates this analysis through
5 2004.

6 In this analysis we group hospitals into groups
7 based on whether the hospital consistently had a negative or
8 positive overall Medicare margin every year over a four-year
9 period, and in this case from 2001 to 2004. We find that 34
10 percent of hospitals had consistently negative Medicare
11 margins over this period and that 28 percent had
12 consistently positive margins. Of note is the small share
13 of hospitals, less than 3 percent not shown in the chart,
14 that had both negative Medicare and negative total margins.
15 That's total all-payer margins from all payers.

16 Our analysis today focuses on the cost-influencing
17 factors that may contribute to poor or good financial
18 performance for these two groups of hospitals. As you can
19 see in the overhead, the consistently negative margin group
20 had smaller average changes in Medicare and all-payer
21 lengths of stay as compared with the positive margin group
22 or the all hospital group. Similarly, occupancy rates were

1 lowest in the negative margin group and highest in the
2 positive margin group. Higher occupancy rates should
3 translate into lower unit costs as fixed costs are spread
4 over more units of output.

5 We next move on to a measure of cost where we
6 standardize for case mix and patient severity using APR-
7 DRGs, outliers, wage index, teaching and disproportionate
8 share. What we find is that negative Medicare margin
9 hospitals have much higher standardized cost per case, about
10 7 percent higher than the median for all hospitals and 19
11 percent higher than the positive margin group. We also see
12 that the negative margin group had a bigger average annual
13 increase in cost per case from 2001 to 2004, one full
14 percentage point higher than for the positive margin group.

15 We also find that total all-payer margins, which I
16 don't have on this chart, are higher for the negative margin
17 group than for the positive margin group. The negative
18 margin group, therefore, may be under less financial
19 pressure to reduce their costs which may partially explain
20 their circumstances we're finding here.

21 Finally, I want to move on to compare these
22 providers with their neighbors. Among the two negative

1 margin groups we see that their neighboring hospitals have
2 stronger financial performance with higher occupancy rates
3 and lower standardized costs per case.

4 Now Jack is going to come back and talk about
5 hospital efficiency.

6 MR. ASHBY: This analysis assesses the effect of
7 consistently high-cost hospitals on Medicare margins. We
8 compared hospitals costliness based on the standardized
9 cost-per-discharge measure that Craig described a moment
10 ago. Then we identified a hospital as high cost in two
11 ways: by its falling into the high quarter or its falling
12 into the high third of all hospitals in both 2002 and 2004.
13 We believe this dual test is important because it guards
14 against the possibility that either a data problem or some
15 special circumstance -- being hit by a hurricane would be a
16 timely example -- explains a hospitals' high cost.
17 Basically, lightning would have to strike twice for a
18 hospital to inaccurately be identified as high cost.

19 Our table compares our two groups of consistently
20 high-cost hospitals in the first two rows to all hospitals
21 and then to consistently low-cost hospitals. In the first
22 column we see that only 14 percent of hospitals remained in

1 the high quartile both years, and 21 percent remained in the
2 high third both years. A substantial share of the high-cost
3 hospitals in 2002, about 40 percent of them, managed to turn
4 their performance around by 2004.

5 In the middle column we see that the persistently
6 high cost groups actually had above average cost growth in
7 the intervening years, so obviously they have not improved
8 their situation.

9 And then in the far right column we see the
10 tremendous difference in financial performance between the
11 high and the low-cost groups from highly negative to highly
12 positive.

13 We found that rural and non-teaching hostels were
14 more likely than their counterparts to be in the high-cost
15 groups, but much of this difference was driven by a single
16 subset of hospitals, sole community hospitals, many of which
17 are paid above PPS rates. Perhaps not surprisingly, we also
18 found that government hospitals are over-represented and
19 for-profit hostels are under-represented in the high-cost
20 groups.

21 Focusing on the our forecast for 2006 we found
22 that excluding just the 14 percent of hospitals with costs

1 consistently in the high quarter from the calculation raises
2 the overall Medicare margin by more than a full percentage
3 point from minus 2 to minus 0.7, to be exact. And excluding
4 the 21 percent of hospitals that had consistently high costs
5 as measured by being in the high third raises the margin by
6 more than two percentage points to 0.1 percent on the
7 positive side.

8 Turning to our update recommendations, we would
9 first conclude that current payments are adequate in light
10 of the continued need for cost containment, the need to
11 limit Medicare's payment to covering costs of efficient
12 hospitals, and our positive findings on the other payment
13 adequacy factors.

14 The Commission's productivity factor is 0.9
15 percent, derived from the 10-year average of total factor
16 productivity growth in the general economy. But balancing
17 the importance of constraining costs with concern about the
18 trend in Medicare margins, our draft recommendations call
19 for updates of market basket minus half of expected
20 productivity growth for both inpatient and outpatient
21 payments. That's what shown on the next slide, and you can
22 perhaps save a moment by not reading the full language here.

1

2 The Commission also represented market basket
3 minus half of productivity last year, but our estimate of
4 productivity growth in the general economy at that time was
5 0.8, resulting in a recommendation of market basket minus
6 0.4 in contrast to what is now quantified as market basket
7 minus 0.45. The actual update for fiscal year 2006, the
8 year that just started, actually was market basket even.

9 The implication of these draft recommendations for
10 Medicare spending is a decrease relative to the current
11 baseline and we expect no major implications for
12 beneficiaries or providers.

13 So I now turn the presentation over to Dan.

14 DR. ZABINSKI: At the November meeting I discussed
15 the issue that many rural hospitals receive what are called
16 hold harmless payments under the outpatient PPS. Without
17 these hold harmless payments the financial performance of
18 rural hospitals under the outpatient PPS will be much worse
19 than that of their urban counterparts. The issue facing the
20 rural hospitals is that these hold harmless payments expire
21 in a few weeks at the end of calendar year 2005.

22 I think a fair question right now is, why not

1 address this issue of the relatively poor performance of
2 rural hospitals by simply making the hold harmless payments
3 permanent policy? But the problems with the hold harmless
4 payments is that they don't always efficiently target the
5 appropriate hospitals.

6 For example, they can provide additional payments
7 to hospitals that are already in some financial
8 circumstances without the hold harmless payments.
9 Therefore, the hold harmless payments are more costly to the
10 Medicare program than is necessary to address the relatively
11 poor performance of rural hospitals under the outpatient
12 PPS.

13 Also in November I discussed two policies that
14 would more efficiently address this issue. One issue
15 involves the potential recalibration of the outpatient PPS
16 so that payments more accurately match the costs of
17 furnishing individual outpatient services.

18 The other policy addresses an issue of rural
19 hospitals tending to have relatively high costs per
20 outpatient service because they generally have lower service
21 volumes than their urban counterparts and, therefore, the
22 rural hospitals are in a lesser position to take advantage

1 of economies of scale.

2 I believe the best policy for addressing the high
3 cost per outpatient service among the low volume hospitals
4 is a low volume adjustment, in particular one where the
5 lowest volume hospitals would receive the highest adjustment
6 rates and then the adjustment rate would decline as hospital
7 volume increases.

8 Also, a good low volume adjustment should have a
9 distance requirement where a hospital would have to be at
10 least a minimum distance from any other hospital furnishing
11 outpatient services in order to receive a low volume
12 adjustment. In November I suggested the idea of perhaps a
13 25-mile distance requirement. The basis for that is that
14 the low volume adjustment for inpatient services has a 25-
15 mile distance requirement.

16 Also at the November meeting some commissioners
17 wondered whether other ambulatory providers, such as
18 ambulatory surgical centers and rural health clinics,
19 should be also considered when you think about whether a
20 hospital meets a distance requirement. I think that's a
21 valid issue and it's something that we do discuss in the
22 briefing materials that the commissioners have.

1 However, the data that we have really aren't rich
2 enough to tell us how well these other ambulatory providers
3 substitute for the care provided in outpatient departments.
4 So at the current time we really can't address this issue
5 but it is something we should be attentive to into the
6 future.

7 Now on a strongly related issue, in 2006 CMS
8 intends to begin using a policy that will provide additional
9 outpatient PPS payments to sole community hospitals that are
10 located in rural areas. The purpose of this particular
11 policy is similar to the low volume adjustment I've been
12 discussing, that is to address the relatively poor
13 performance under the outpatient PPS of rural hospitals.

14 I believe the low volume adjustment is a better
15 policy than CMS's intended adjustment for the rural SCHs.
16 First of all, because the adjustment for the rural SCHs is
17 too broad and perhaps too imprecise, and that it provides
18 additional payments to hospitals that are not necessarily
19 vital to beneficiaries' access to outpatient care, and also
20 provides additional payments to hospitals that are already
21 in some financial condition, while at the same time it may
22 not provide additional payments to hospitals that are facing

1 difficult financial circumstances.

2 In contrast, the low volume adjustment is more
3 efficient in that it targets hospitals that are vital to
4 beneficiaries' access to care as well as targeting low
5 volume hospitals facing difficult financial circumstances.

6 In response to that I've drafted this
7 recommendation that the Congress should enact a graduated
8 low volume adjustment to the rates used in the outpatient
9 PPS. This adjustment should apply only to hospitals that
10 are more than 25 miles from another hospital offering
11 outpatient services.

12 In the first sentence, the term graduated low
13 volume adjustment means, at least from my perspective means
14 that providing the highest adjustment to the lowest volume
15 hospitals and then having the adjustment rate decline as
16 hospital volume increases.

17 The spending implications of this policy is that
18 it would have a very small budget effect. At this point I
19 want to also add that this policy would have no effect on
20 the payment for critical access hospitals because those
21 hospitals are exempt from the outpatient PPS, and that was a
22 point of confusion in November.

1 Then to close, the beneficiary implications is
2 that it would help assure their access to hospital
3 outpatient care.

4 Now I turn things over to the Commission for their
5 discussion.

6 MR. HACKBARTH: I'm going to remind people again,
7 just to make sure the message sinks in, that the draft
8 recommendations, in this case, the draft recommendation on
9 the update is a carryover from last year, what we
10 recommended last year.

11 It might be helpful, Jack, or all of you in
12 unison, to compare this year's situation and payment
13 adequacy to last year. Are there material differences in
14 either direction that we ought to be aware of?

15 MR. ASHBY: Yes. The two that I would cite are,
16 first, that we have some evidence that the rate of cost
17 growth has been coming down over what we had available to us
18 last year. That includes a further potential step downward
19 in 2005 from the survey that we co-sponsored with CMS.

20 And secondly, in looking at the adequacy of
21 payments I can't overestimate how much difference the
22 outliers make. It's kind of a side issue here but it makes

1 a lot of difference in looking at the adequacy of payments.
2 We are now in a position to say fairly confidently that CMS
3 is achieving some success in restoring outlier payments to
4 what they should be. Much of that has already been
5 accomplished for 2005. And the 2006 outlier threshold is
6 lower and it indicates that it will happen. So that
7 contributes to a better picture than we were looking at one
8 year ago.

9 MR. HACKBARTH: Questions, comments?

10 MR. MULLER: A couple of questions and comments.

11 On the face of it when we have a minus two projection on
12 payments and say that the payments are adequate, is that
13 largely based on our analysis of what you call the negative
14 margin hospitals that if you can exclude the negative margin
15 hospitals, or the consistently negative margin hospitals
16 from the analysis then you're a little closer to break even?
17 Is that how we're basing that?

18 MR. ASHBY: It's not excluding the negative
19 margin, per se. It's excluding those with consistently high
20 cost growth that one would label high-cost hospitals. In
21 the absence of those hospitals, just in the calculation, we
22 would have a margin that's basically in the range of

1 covering the costs of care.

2 MR. MULLER: So in that sense we're saying it's
3 adequate for the hospitals that don't have negative margins.

4 DR. MILLER: I would state that a little bit
5 differently. I would say, in responding to the question,
6 there's factors other than the margins that are playing into
7 this and we've reviewed those factors and some of those
8 relatively positive. I guess in saying this, this is our
9 attempt, and you could characterize it as crude, but our
10 attempt to respond to, what is the efficient provider?
11 That's something that Congress has pushed us and made as
12 part of our mandate. So you can take issue with the
13 analysis but the attempt is to say, is this a way to think
14 about the efficient provider? I think it's in that context
15 we're making the point.

16 MR. MULLER: We do show that quite a bit of the
17 higher costs and the consistently negative margins are in
18 the hospitals that have lower occupancy. That, obviously,
19 intuitively makes sense, if you have lower occupancy and you
20 spread fixed costs, you have higher costs and more negative
21 margins. At the same time in the introductory comments we
22 have more and more hospitals going to critical access.

1 So are we driving more and more hospitals towards
2 securing or attempting to secure critical access status?
3 Could you just comment a little bit on that, because the
4 extent to which we have these -- again, I assume that the
5 critical access hospitals are not in this sample, correct?

6 MR. ASHBY: Right.

7 MR. MULLER: These are just the PPS. So to the
8 extent to which we have these lower occupancy hospitals with
9 higher costs, which again makes intuitive sense, if you have
10 lower occupancy you likely have higher costs and lower
11 margins -- are these hospitals that are going to be able to
12 qualify for critical access or these are the ones that
13 really are outside the critical access rules in terms of
14 location?

15 MR. ASHBY: Let me comment in two ways about that.
16 Generally, we're saying that hospitals with low occupancy
17 are in competitive situations. Craig's analysis showed that
18 they're occupancy is lower than the hospitals in their
19 markets, so they are essentially losing out in competition.
20 As for areas where access to care might be a concern in some
21 of these rural areas, then we do have 1,100 hospitals,
22 almost 1,200 hospitals that are in the critical access

1 program so they're not subject to the constraints that we're
2 talking about today. And in addition to that, we have a
3 program, the sole community hospital program, that gives
4 higher rates of payments as well for hospitals that are
5 isolated. Actually not all of them are isolated, but the
6 program is designed to provide higher rates for those that
7 are isolated where access to care may be a concern.

8 So by balancing those two things --

9 MR. MULLER: So because of those rules on which
10 ones get to be critical access, we're not as likely to take
11 these third of hospitals, 30-some percent, that the negative
12 margins and drive them over to critical access, right?
13 Because there are rules they have to comply with to get into
14 that.

15 MR. ASHBY: That's right.

16 DR. STENSLAND: We expect no more critical access
17 hospitals, or almost no more critical access hospitals at
18 the start of the year because they're getting rid of the
19 state waivers, so critical access hospitals will have to be
20 either the 35 or the 15 miles from another provider and
21 there's almost no hospitals left that meet that criteria, of
22 small size that might to convert to critical access.

1 MR. ASHBY: We've already reached the point where
2 over half of rural hospitals are in the critical access
3 program.

4 MR. MULLER: Let me just ask another factual
5 point. In terms of our estimates for the margins for 2006,
6 as you pointed out, there's a variety of policy changes and
7 then we have some limits on hospital SNFs and we have the
8 rehab rules, et cetera. You've taken all those into
9 account? I heard Jack's qualifier on how you put the
10 outlier provisions in because you're assuming that the
11 outlier payments will be a target rather than where they are
12 right now. But basically all those four or five other
13 changes in terms of the expansion of the transfer rules, the
14 rehab, the hospital SNFs, those are all --

15 MR. ASHBY: They have all been accounted for on
16 the payment side of our projection.

17 MR. MULLER: It does surprise me that with a cost
18 growth at the 5.8, the 5 percent over the last few years
19 that the negative margin hasn't increased; that there isn't
20 more of a negative margin, especially you have both the
21 higher cost growth and you have these other factors, the
22 ones you just mentioned. Maybe the outlier is so strong the

1 other way that it outweighs the -- because the acute
2 transfer rules should probably have a minus one percentage
3 point effect. I mean the expansion of the transfer DRGs.
4 So it just surprises me, because in the past we have tended
5 to underestimate what the margin will be in our forecast
6 year because by and large, one, we underestimate the cost
7 growth. We usually estimate it's going to be three and we
8 always have this annual thing it turns out to be five or
9 whatever, so the margins tend to be greater. So I'm just a
10 little surprised that given the cost growth that we have
11 here --

12 MR. ASHBY: But two comments though, and one is
13 the outliers. I just can't overestimate how much difference
14 that makes. Outliers is a \$5 billion program. And the
15 restoration of outlier payments to their target level
16 actually has a greater positive impact than does the
17 transfer policy in the other direction.

18 But the second comment I would make is that, in
19 addition to a couple of policy changes that do have a
20 downward impact on payments, we do have several payment
21 policies going into this projection that increase payments.
22 We have the expansion of disproportionate share payments.

1 We had the one-time appeals of geographic reclassification,
2 for example, which is a \$900 million, three-year program,
3 and several other smaller ones.

4 DR. MILLER: If I could just say, Ralph, this same
5 set of questions came up when I got this in front of me the
6 first time too. How can we hit minus 3 and then at minus
7 two? And the answer was the same, just so you know.

8 But I want to emphasize a point here on the
9 outlier point because I drilled down on this little bit.
10 We're assuming that it is restored and our best -- not our
11 best guess. What we know at the moment is that has been
12 brought up to 4.7 percent of payments.

13 MR. ASHBY: Right, two-thirds of it has already
14 been restored.

15 DR. MILLER: I wanted to know how sure we could be
16 that we thought they might come back up to 5 percent, and
17 they're on a path back up. I thought I heard you guys say
18 at one point in our discussions, they're at 4.7 percent.

19 MR. ASHBY: Right, for 2005. Plus the outlier
20 threshold for 2006 is lower than the threshold for 2005.
21 Certainly, that augurs for greater outlier payments.

22 MR. HACKBARTH: Jack, could I follow up on a

1 couple of Ralph's questions about how we project? My
2 understanding of what you said was the protection from the
3 actual cost data in 2004 forward to 2006 was based on the
4 evidence we have on actual cost growth from the survey of
5 hospitals and I'm blanking on the other source right now.

6 DR. STENSLAND: It's the publicly-traded
7 hospitals.

8 MR. HACKBARTH: So it's the average of those two
9 numbers, one was 4 percent and the other was 5 percent, so
10 we rolled forward the 2004 data by 4.5 percent each year,
11 correct?

12 MR. ASHBY: Right.

13 MR. HACKBARTH: Now in the past, as Ralph points
14 out, we have tended do under-project the cost growth and
15 therefore over-project on the margins. My recollection is
16 in the past we used a different projection approach and at
17 least, for like the last year we would tend to use market
18 basket. Could you just describe the change in the
19 projection rules?

20 MR. ASHBY: Last year and the year before we would
21 assume a rate of cost growth based on the data again for the
22 first of the two years and then assume market basket for the

1 second of the two years. This time we have assumed recent
2 cost growth, as Glenn described, for both years, 2005 and
3 2006.

4 MR. HACKBARTH: You're right about the history of
5 the projections. So that's being done a little bit
6 differently to try to get more accurate on that.

7 The other piece of the projection is that in the
8 2006 projection we also take into account any new policies
9 that are scheduled to go into effect in 2007. Were there
10 any significant --

11 MR. ASHBY: One policy that we did take account of
12 there was the one-time appeals of geographic
13 reclassification. That is scheduled to go out in the middle
14 of 2007. We accounted for it in that way. Whether Congress
15 will extend the program, it's quite possible but we don't
16 know.

17 MR. HACKBARTH: So you're saying the projection
18 assumes that it's going to be eliminated in the middle of
19 2007 and people are going to fall back to their older, lower
20 payment levels?

21 MR. ASHBY: Right. We actually estimated payments
22 as if it were in effect for half the year and no in effect

1 for the second of the year. That was the most precise way
2 that we could do it.

3 MR. HACKBARTH: That begs the question of whether
4 in fact that's likely to happen.

5 MR. MULLER: This is probably more technical than
6 we usually do, but when you see costs going up in our
7 projection 4.5 and the update may be around three or so,
8 just that's a big outlier effect, and maybe the geographic
9 reclassification as well. You would assume the margin would
10 get more negative. So just trying to follow exactly how we
11 do that calculation. Those are more technical.

12 I'm sure, based on some of my colleagues, there's
13 going to be a pay for performance discussion here so I will
14 weigh in later on that one.

15 DR. WOLTER: A few points. I guess I think it's a
16 stretch at best to say that payments are adequate if you
17 exclude the one-third of the high-cost hospitals and end up
18 with an overall margin of plus 0.2 percent. We've talked in
19 the past about what overall margin is adequate and we, I
20 guess probably rightly decided, we wouldn't pick one.

21 MR. ASHBY: Let me just clarify though, it's
22 excluding the one-fifth of hospitals that had costs

1 consistently in the high third. So it was really only one-
2 fifth of the hospitals.

3 DR. WOLTER: But regardless, I think we are on a
4 little bit shakier ground this year than maybe in past years
5 on that particular statement, just as a personal point of
6 view.

7 Then I guess for the record I do have a dissenting
8 point of view on the theory that's being proposed in the
9 chapter that the private sector leverage is the cause of the
10 increasing costs. What I don't see in the chapter is enough
11 balance around some of the real issues that are going on in
12 terms of investment in technology, costs of HIPAA, privacy,
13 security measures, the labor cost issues that have really, I
14 think, increased in recent years around nursing, physician
15 and other, pharmacy, other highly technical positions, the
16 cost of liability insurance, particularly as more physicians
17 are being employed.

18 Some of those factors are the cause of the
19 increased cost, not just the fact that there's private
20 sector leverage. It would be nice to have a little balance,
21 at least in the text around that. I don't think it's as
22 balanced as it might be.

1 Also, I don't think all markets are the same in
2 this country in terms of the potential for leverage into the
3 private sector. I certainly think there are a number of
4 markets where that particular leverage is more difficult and
5 cost shifting is certainly more difficult. I think the
6 argument that relative underpayment in the Medicare system
7 might in and of itself be a cause of trying to leverage the
8 private sector has some merit.

9 Having said that, I certainly agree that when you
10 have leverage in the private sector it allows you to look at
11 your costs differently. So I'm not disagreeing with it. I
12 think the story is more complicated than we have presented
13 it.

14 Then I think that there are some other things that
15 do concern me a little bit. I remain concerned that as we
16 continue to not look more carefully at the negative
17 outpatient margins that will have downstream effects in
18 terms of where hospitals make their investment, and their
19 investments will tend to concentrate on those highly
20 profitable inpatient services. We may find ourselves with a
21 problem in future years if we don't try to address, do we
22 have an issue with negative 10 percent outpatient margins or

1 are we so sure on cost accounting issues that we can
2 continue to ignore that? I worry about it.

3 I'm a bit worried about the technology question.

4 We used to have the 0.5 percent adjustment for technology.

5 The current mechanisms to address technology in the payment
6 system are fairly specific to individual new technologies
7 and really don't cover some of the larger system technology
8 needs that are currently on the table.

9 So those are some of my concerns on the inpatient
10 and outpatient update.

11 I do think sustainability of the Medicare program
12 is a good reason to be careful about how big the update is.
13 We have a serious budget problem in this country so to me
14 that's fair game.

15 Then lastly, on the rural outpatient issue, I am
16 100 percent philosophically on board with a low volume
17 adjuster probably being a better approach than certainly
18 permanent support. However, I'm a little bit worried about
19 how much we are reducing that support in this near-term time
20 frame. If I'm remembering what the chapter said right, the
21 current proposal would reduce to about 17 percent of rural
22 hospitals that would receive some kind of support through

1 the low volume adjuster. Is that what I'm remembering?

2 The concern I have is if you look back at the
3 history of the critical access program it actually was the
4 outpatient sector that was causing the margin problems in
5 those small, rural hospitals. I think the fact that it took
6 quite a while to think about that issue led to a movement in
7 the industry to create that cost-based reimbursement system.

8 Had we been perhaps more aggressive with low volume
9 adjustment early on in that group of hospitals we might not
10 have a critical access program today. I don't know where
11 every one is but there's a group of institutions now that
12 call themselves tweeners that are actively pushing Congress
13 to increase up to 50 beds the hospitals that would have
14 cost-based reimbursement available to them.

15 So I'm just a little bit worried if we go too far
16 in terms of the support to these remaining PPS rural
17 hospitals in terms of reducing it, we may see ourselves
18 again with a movement to push cost-based reimbursement
19 further than it is today. So it's just an angst I have
20 about the recommendation.

21 MR. HACKBARTH: Could I ask about that? You said
22 that you agreed conceptually that we ought to target the

1 assistance to low volume. Where would you liberalize it if
2 you were going to liberalize the proposal, reduce the
3 mileage so more hospitals qualify?

4 DR. WOLTER: I think that actually has good
5 rationale. I'm not sure how sure we are that 25 miles is a
6 good proxy for access because, as we've discussed in the
7 past, in some markets both of those institutions, even
8 though they're low occupancy, may have good reason to exist.
9 So going to 15 miles might be one thought. Creating a
10 transition over several years to better understand what we
11 have going on might be another possibility.

12 You look at those rural margins of the remaining
13 PPS hospitals and they do remain still more negative than
14 the urban margins. If we take away the support for the
15 outpatient side and those margins get worse I'm just afraid
16 that a number of different reactions will occur, including
17 this --

18 MR. HACKBARTH: Could we talk for just a second
19 about the 25 miles? Obviously one reference point there is
20 that's the mileage used for the inpatient low volume
21 adjustment.

22 On the other hand, there are a bit different

1 dynamics when you're talking about outpatient services than
2 inpatient and I'm not sure which way they cut. On the one
3 hand you're more likely to make the trip for outpatient
4 services more frequently, in which case any given distance
5 might become more burdensome. On the other hand, for
6 inpatient it's more likely to be something that you've got
7 to get their fast.

8 Have you thought about the 25 miles and whether or
9 not it would be different for outpatient? What did you
10 conclude there? Obviously you concluded it shouldn't, but
11 what was the thought process?

12 DR. ZABINSKI: Actually, my initial thoughts on
13 this were actually back to the initial recommendation we
14 made for the inpatient, which was a few years ago, which was
15 15 miles and the first simulations I ran looking at how many
16 hospitals qualify for a low volume adjustment, what sort of
17 budget impacts, et cetera, were using a 15-mile requirement.
18 Just as a back of an envelope estimate, you multiply
19 everything by a factor of three if you go down to a 15-mile
20 requirement. By that I mean, the fraction of rural
21 hospitals that would qualify goes from 14 percent up to 41
22 percent. The budget impact also goes up by a factor of

1 about three.

2 But then after a little more thought on how the
3 legislative process worked out, that the Congress arrived at
4 a 25-mile requirement, and that's why I ultimately chose to
5 present that particular number.

6 DR. MILLER: I don't want to put too much science
7 on this. You can discuss this, so we started with the
8 inpatient reference point.

9 MS. DePARLE: First, I agreed with what Nick had
10 to say about outpatient margins and the need to be able to
11 more carefully consider what's going on there and have
12 better analysis of that. I think he's raised this for at
13 least the last two years, and I know it's difficult -- we
14 probably just don't have the data -- but I think he's right,
15 that we need to understand better what's going on there.

16 Secondly, on the section in the written document
17 about access to capital, I made a comment at the last
18 meeting about a report that had been issued by one of the
19 three major rating agencies saying that they were going to
20 take into consideration -- it was a pretty strong report
21 actually -- whether or not a hospital had clinical
22 information systems and if they did not it would be

1 something that they would consider for negative ratings. I
2 did find that report and sent it to Mark.

3 Also, I mentioned that I had understood that the
4 agencies are now looking as well at compliance with
5 Sarbanes/Oxley or something like it and increased
6 requirements around governance and financial reporting among
7 non-profit hospitals. I think that's something that, for
8 lots of reasons including perhaps the first that Nick raised
9 and I raised about data, that we would support better
10 governance, more transparency, all those things, but that
11 will have costs.

12 I did find the three major rating agencies in the
13 last literally month, one last week, have all issued reports
14 on this. Not yet saying it will be required, you will be
15 negatively rated or downgraded, but all three saying, we're
16 going to start looking at this more carefully, and one
17 saying that it may positively influence a hospital's rating
18 if they follow the Sarbanes/Oxley-like requirements. So I
19 believe that should either go in this chapter under the
20 access to capital as something that we're monitoring, or
21 under costs, because it belongs in one of those two places.
22 The costs, I think, are going to be increasing.

1 Finally, I was curious. We don't say anything in
2 here, and maybe there was a discussion I missed earlier
3 about this, but we don't really say anything about what our
4 view is of the -- it's not an experiment, but the
5 requirement that Congress imposed for hospitals to
6 voluntarily report data in order to receive the full market
7 basket, which I guess goes through 2007. What has that
8 shown us so far? What do the data show? And the premier
9 demo, I guess we don't really talk about that either. What
10 is MedPAC's view of that?

11 I guess that leads me to the subject of, have you
12 considered or should we be considering some more robust pay
13 for performance recommendation here? Maybe that's what
14 Ralph was alluding to.

15 MR. HACKBARTH: Could we just touch on this
16 outpatient cost allocation issue? Nick has raised that
17 several years. I think it's important that we not ignore
18 it. So, Jack, do you want to just talk about what we've
19 done to try to --

20 MR. ASHBY: Let me point out two things. First of
21 all it would be stating the obvious to say this is a
22 continual source of frustration that we have gotten to the

1 bottom of this issue. We have plans for another go at it
2 after the holidays, and a different analytical technique, to
3 try to answer the question about how accurate the relative
4 margins are. That's the best answer I can give at the
5 moment.

6 But I would also point out that the inpatient and
7 outpatient margins, as they are currently measured, do show
8 that the gap between the inpatient and outpatient margins
9 has narrowed by four percentage points in just the last two
10 years. There's a lot of policy changes that affect that,
11 but mostly that's capturing the difference in rate of cost
12 growth that Jeff put up. We have low outpatient cost growth
13 and so --

14 DR. WOLTER: Isn't that because the decline in the
15 inpatient is faster than the decline in the outpatient
16 margin, in essence? That's what's narrowing the gap.

17 MR. ASHBY: It does reflect our pesky outlier
18 issue, which for 2004 brings inpatient payments down. But
19 it also reflects the difference in cost growth. We do have
20 two years of very low outpatient cost growth and that is
21 going to improve outpatient financial performance however we
22 might be measuring it.

1 MR. LISK: I want to add something though. We
2 also see large volume increases on the outpatient side.
3 That's again to remind you what Jeff had, is that's one of
4 the reasons why we see the lower cost growth on the
5 outpatient. So it's the same type of situation we have with
6 physicians where we see volume growth could be a reason for
7 some lower cost growth.

8 MR. HACKBARTH: So as I think you know, Nick, it's
9 not that any of us think that the issue is unimportant that
10 you're raising, do we have the cost allocations right?
11 There has been a reluctance to assume that the reported
12 allocations on the cost reports are accurate. We've tried
13 at least a couple different approaches to get to a better
14 number, thus far unsuccessfully, but we're continuing to try
15 to find a way to address your issue. It certainly is a
16 legitimate and important one.

17 DR. STOWERS: I also had a question on the rural
18 payments there. Nick made many of the same points that I
19 was going to make so I won't go back over all of those. I
20 would totally agree that we're maybe making a step in the
21 right direction with the low volume adjustment. It would be
22 great to be in a world where we didn't need cost

1 reimbursement at all, if we could correct for all of the
2 things that affected the difference in PPS for the rural
3 hospitals.

4 But that brings me around to, the reason for the
5 outpatient hold harmless was for myriad different reasons,
6 not just low volume. I think it was our 2003 report that
7 listed a bunch of those. I'm just kind of curious, when we
8 get down to maybe that the budget impact is a small one, is
9 the proposed low volume adjustment that you're talking
10 adjusting for all of these factors that brought about the
11 hold harmless payment? Or are we looking at an increase in
12 payment to rural hospitals? Because we definitely made the
13 statement, outpatient financial performance is much worse
14 without the hold harmless. Are we coming out on these rural
15 hospitals to the positive, to the negative with this?

16 DR. MILLER: Let me try and address at least --

17 DR. STOWERS: I'm trying to get a feel for the
18 overall impact here on the --

19 DR. MILLER: Let me say at least a couple things.
20 I think, to take your question apart into pieces, it
21 definitively does not address all things that might have
22 been addressed by the hold harmless. The hold harmless

1 basically says, if you're going to realize any negative
2 impact it won't be allowed to happen. So it doesn't address
3 all of those factors.

4 I think what our analysis said is, what would
5 legitimately be something that a prospective payment system
6 would want to correct for in a low performance hospital, and
7 it was the need for access and the fact that they had low
8 volume because they were so far removed from other -- they
9 were in a remote area.

10 It is a small budget impact. In our typology
11 which we've used in proceeding years and we haven't talked
12 about a lot here, it's less than \$50 million in one year, I
13 believe. But the point I wanted to make, in case this was
14 part of your question and I wasn't sure it was, we're seeing
15 this as an increase. This is not a budget neutral
16 adjustment. This would be new money that would go into the
17 system.

18 DR. STOWERS: That was my question. So in essence
19 they're gaining a little.

20 DR. MILLER: That's correct.

21 DR. STOWERS: But it would be a redistribution
22 between the --

1 DR. MILLER: It's new dollars.

2 DR. STOWERS: But I meant in total, the hold
3 harmless money would be better distributed to those of low
4 volume versus those --

5 DR. MILLER: But just to be clear, I don't think
6 it's dollar for dollar. The hold harmless money ends at the
7 end of this year. So this is saying, if that's going to be
8 gone, this is the policy we recommend and it is new dollars.
9 But it's not dollar for dollar on the hold harmless.

10 MR. HACKBARTH: What are the relative magnitudes?

11 DR. ZABINSKI: With the 25-mile distance
12 requirement it's one-tenth as large as the hold harmless.
13 As I said, if you go with a smaller distance requirement,
14 such as 15, with the 15-mile requirement it would be one-
15 third as large as the hold harmless perhaps.

16 DR. STOWERS: Does that mean there's a loss of 90
17 percent or of two-thirds of total dollars into these rural
18 hospitals?

19 MR. HACKBARTH: From this particular adjustment.
20 He's saying with the hold harmless -- what's the magnitude?

21 DR. ZABINSKI: It's about \$150 million a year.

22 MR. HACKBARTH: \$150 million, If you have a 25-

1 mile limit it goes down to like \$15 million in new dollars?

2 DR. ZABINSKI: Right.

3 MR. HACKBARTH: If you go to a 15-mile limit it
4 would go up to about \$45 million in new dollars.

5 DR. STOWERS: I guess my concern here is the
6 timeliness of all of this. If we're talking that low of
7 dollars, but on one hand we're saying that financial
8 performance would be much worse for this particular set of
9 hospitals and this thing is expiring the end of 2005, I'm
10 not so sure -- and I'm not trying to perpetuate a bad system
11 but I'm not so sure we shouldn't be saying we should extend
12 the hold harmless until some kind of low volume or something
13 can be put in, because this low volume can't be put in
14 overnight. And even at that it looks like it's going to
15 allow for a relatively small part of what's going to be lost
16 in the hold harmless. So I'm trying to get a grasp on how
17 this timing is going to work for 2006 and 2007.

18 DR. ZABINSKI: We did recommend last year
19 extending the hold harmless for one year through calendar
20 year 2006 with the intent purpose of examining this issue
21 and coming up with a policy that more directly addressed the
22 relevant issues affecting the issues facing the rural

1 hospitals. So the intent purpose of this particular policy,
2 the low volume adjustment, would be like 2007.

3 DR. STOWERS: I'm not totally against that. I'm
4 just wondering why would not be recommending -- knowing the
5 negative impact that's hanging there -- why we wouldn't be
6 recommending the continuation of the hold harmless until
7 another system can be put in place.

8 DR. ZABINSKI: Exactly.

9 DR. STOWERS: I'm not sure we're saying that.

10 DR. MILLER: I think we have said that and the
11 Senate Finance bill does have a continuation. So we've made
12 that recommendation, at least the Senate Finance side --

13 DR. STOWERS: We made it 2006.

14 MR. HACKBARTH: But that ought to be enough time
15 to do the low volume for 2007. We ought to be able to do it
16 within calendar year 2006.

17 The real problem is that as yet our recommendation
18 of continuing it through 2006 has not been enacted because
19 there's not been a Medicare bill passed. But it's not
20 because we didn't recommend it. We have recommended it. It
21 just hasn't happened yet.

22 DR. REISCHAUER: A couple of questions. I want to

1 ask Jack about outliers. The pot went to around 3 percent.

2 MR. ASHBY: 3.5.

3 DR. REISCHAUER: And it's going to be brought back
4 up to where it should be, around five.

5 MR. ASHBY: 5.1.

6 DR. REISCHAUER: That clearly will affect margins
7 in the aggregate.

8 But the question I have is, what about the
9 distribution of this? We know that all hospitals don't
10 avail themselves of the outlier provision equally. Certain
11 types do. Do we know whether those that are likely to
12 receive the greatest amount of this additional two
13 percentage points will be those that already have positive
14 margins? Or will they be largely those that don't have
15 positive margins? Of course this is money that comes out of
16 the overall payment for everybody else.

17 MR. ASHBY: I think the most important point is
18 that once we get to the point where it is operating as it is
19 supposed to, and that's what we're heading towards, then the
20 money will go to those hospitals that are incurring the
21 additional costs of treating outliers. That's the real
22 point.

1 As to whether those hospitals that are incurring
2 the costs are the ones with the high margins, many of them
3 are, because they are teaching hospitals that have a little
4 bit higher margins than others because of the IME payments.
5 But that's really an IME payment issue and not an outlier
6 issue.

7 DR. REISCHAUER: I confess to having known a
8 little bit about the answer before I asked the question.

9 MR. ASHBY: I think it will go to the appropriate
10 hospitals in terms of the costs incurred, as the system is
11 designed to do.

12 DR. REISCHAUER: But if we get a distribution of
13 numbers of hospitals that have negative margins that might
14 not change very much.

15 MR. ASHBY: Not very much, I would think, but we
16 haven't done that specific analysis.

17 DR. MILLER: The IME point is part of the point,
18 but also the specialty hospital work suggested that there
19 was possibly some refining to be the outlier policy as well.
20 So I would say your question is a good one on at least a
21 couple of fronts.

22 DR. REISCHAUER: Dan, when Nick said 17 percent of

1 the rural hospitals would be affected by this and you were
2 looking perplexed and looking at your notes, I don't
3 remember reading any number like that. Maybe there was one
4 there and I just missed it.

5 DR. ZABINSKI: It's 14 percent.

6 DR. REISCHAUER: But I was just thinking, if we
7 think of all rural hospitals, how many are left when you
8 take out sole community hospitals, take out critical access
9 hospitals and you take out the ones you're going to give a
10 low volume to for outpatient or who already get it for
11 inpatient, I'm wondering if there's anybody left in the room
12 here. And the Medicare dependent ones.

13 MR. LISK: If you talk rural hospitals that don't
14 get special treatment, there's probably about 450 left. So
15 if you think of the sole community hospitals, the Medicare
16 dependent, and the rural referral centers you're left with
17 about 450 rural hospitals that are just plain, vanilla rural
18 hospitals that don't qualify for any of these special
19 programs. We've reached a turning point where there are now
20 more critical access hospitals than there are rural
21 hospitals including the ones with these special treatments.

22 DR. REISCHAUER: Thank you. A final thing that's

1 really a comment and goes to Nick's concern about outpatient
2 services and perpetually large negative margins that we have
3 for this group of services. I'm just confused because we
4 have very low margins, negative margins. They're getting a
5 little better but they're still quite low. So they are
6 incurring a loss here. And yet the volume of services and
7 their activity in this area is such that they are increasing
8 the business.

9 It's a little like, I lose on every sale but I'm
10 going to make it up in volume. You have to ask yourself,
11 what's going on here, because just from the numbers you've
12 given and the increase in volume you have to think that the
13 aggregate loss is rising each year on this business, if
14 these numbers are right.

15 MR. LISK: The other thing is they're covering --

16 DR. REISCHAUER: Between marginal an average cost,
17 which is --

18 MR. LISK: They're covering their variable costs,
19 is the issue. The more patients they get they're likely
20 covering their variable costs. That may be one reason why
21 the outpatient margin is actually improving slightly even
22 though it's still substantially negative.

1 MR. HACKBARTH: Technology changes, practice
2 changes, and just things that are generally moving from
3 inpatient to outpatient, presumably that has an effect on
4 this also.

5 DR. REISCHAUER: I wonder, given the change in the
6 margin over the last year versus the growth of the volume,
7 whether that's actually true, that the variable cost is
8 being covered.

9 DR. WOLTER: Just real quickly on this question.
10 One point I'd make is I honestly think most of us don't know
11 what our margins are in the outpatient arena because the
12 system is pretty new and the way the bundling has occurred
13 makes it harder to do some of that accounting. So I think
14 we're a little bit murky on it, just as our commission is.

15 MR. SMITH: Bob anticipated two of the things I
16 wanted to mention. I did want to come back to Nancy-Ann's
17 question, which didn't get picked up, is as we look at a
18 similar set of problems to other provider sectors, as we
19 look at what at first glance suggests that we're trying to
20 increase volume, service volume is increasing in order to
21 deal with either low or reduced margins so that -- and you
22 look at where service growth is increasing, in the mailing

1 material. It is increasing in the same places that we've
2 expressed some concern about with respect to physicians, a
3 lot of increase in imaging services.

4 It seems to me we ought to ask yourselves whether
5 or not it is time to begin a process of tying the update,
6 whatever the update is, forget for a moment what we think it
7 should be, but tying a substantial portion of the update to
8 a set of more robust pay for performance measures. We've
9 talked about that. We don't reach it in this chapter
10 although there are the same kind of warning signals, it
11 seems to me, that ought to make us pay some attention to
12 that.

13 Second, let me go where I thought Bob was going to
14 go and he chickened out. Isn't the right response to low
15 volume, high volume? And how we get high volume if we
16 insulate those who would it be performing better with a low
17 volume adjustment?

18 I don't know where those 400 hospitals are, but
19 with something approaching 1,200 critical access hospitals,
20 with Medicare dependent hospitals, with sole community
21 hospitals, it's hard for me to imagine that all 400 of those
22 are for some other reason critical service providers in an

1 otherwise isolated geographic region. The report ought to
2 suggest, it seems to me, that we have an opportunity that we
3 ought not to insulate the system or the providers from, to
4 try to address the question of negative margins being driven
5 by low volume by more consolidation.

6 I don't want to propose a recommendation, but at
7 least it to note that we do have a lot of other insurance
8 systems around to protect access in isolated communities and
9 some assessment of whether or not we need another one, and
10 rather ought to turn this problem on its head and seek to
11 increase volume and the economies of scale that come with
12 it, is something we ought to ask ourselves about.

13 DR. REISCHAUER: I think it's a trade-off between
14 efficiency and access, and that's what the mileage is
15 supposed to do.

16 MR. HACKBARTH: To strike that balance.

17 DR. WOLTER: I think my thesis is that some number
18 of those remaining 450 hospitals probably play an important
19 role in health care delivery. I'd love to have you come to
20 Montana and see what kind of population density gets served
21 by some of these hospitals. But I think you're asking a
22 very good question and maybe there's a way to look at that

1 and look more specifically at these locations, and how they
2 exist relative to other services that are available within a
3 reasonable either time frame or mileage frame. It's a very
4 good question.

5 My angst is, I don't know the answer to it and I'm
6 worried that some of them are important.

7 MR. SMITH: I wasn't suggesting that we
8 prematurely reach an answer. I don't know what the answer
9 is either. I do think if we've got persistently low volume
10 institutions with persistently low all-payer and Medicare
11 payer margins, and for one reason or another they don't fall
12 into a pretty elaborate network now of safeguards against
13 access, that we ought not to create another safeguard before
14 we try to wrestle with the question do we have a better way
15 of understanding when these are crucial? And does a general
16 low volume adjuster address that? I'm skeptical.

17 MR. HACKBARTH: The question I thought you were
18 going to raise before you chickened out was the much bigger
19 question of the overall utilization of capacity in the
20 inpatient/outpatient business across the country. I don't
21 know what the average occupancy rate is right now.

22 MR. ASHBY: It's in the high 50s.

1 MR. HACKBARTH: So to put it in the harshest
2 terms, why should we be trying to assure high profitability
3 or any level of profitability in an industry where we've got
4 50-some percent occupancy?

5 MR. MULLER: Those are really misleading numbers.
6 People don't staff 45 percent beds that are empty. I don't
7 want to get into a debate over how you do your calculation,
8 but there's not 45 percent staffed beds that are sitting
9 empty.

10 MR. HACKBARTH: I'm sure you're right.

11 MR. MULLER: But a practical average, the
12 practical limit is around 80 anyway because most hospitals
13 tend to empty one-third or one-fourth on weekends anyway.
14 Since they take these numbers over seven days, 80 percent is
15 like 100 percent for the other five days. But still
16 obviously, as the numbers show, a higher occupancy/lower
17 average cost, et cetera. But it's not 45 empty.

18 MR. HACKBARTH: I accept that and your points are
19 valid. I think the basic issue still remains though, we've
20 got a payment system in Medicare and among many private
21 payers that does not force the system to higher levels of
22 efficiency by directing patients to the highest performing

1 institutions. We pay higher costs in Medicare and as a
2 society for that method of payment.

3 MS. DePARLE: I meant to raise this earlier and
4 maybe it's not fair game because it a little bit gets into
5 the subject of other than Medicare margins. But since we
6 have a section in the written document about the extent to
7 which cost growth follows changes in the profitability of
8 private sector patients it seems to suggest that they've
9 become more profitable in recent years.

10 It seems to me we should be clear about the extent
11 to which bad debt affects this. At least in the proprietary
12 or for-profit hospital sector -- I don't know the data as
13 well with the not-for-profit sector -- but bad debt is an
14 increasing problem and an issue of real concern to hospitals
15 who are experiencing the logical impacts of high
16 unemployment rates, people losing insurance, everything that
17 we have seen from the reporting that's been done about
18 changes in the commercial insurance market is coming to rest
19 at the doorstep of hospitals.

20 We have one little comment about uncompensated
21 care burdens can also place financial pressure on hospitals.
22 But we sort of characterize it as a positive thing because

1 we say it can put pressure on them to constrain costs.
2 That's true, it can, but it's also an increasing source of
3 concern. Again, perhaps we don't think it's something we
4 should consider because Medicare does have some payments for
5 bad debt that would help with at least Medicare patients,
6 but it seems to me that it's a bit of a canary in a coal
7 mine, at least what I'm seeing.

8 MR. ASHBY: Let me just say this. We don't have a
9 reliable measure of uncompensated care so it's a little bit
10 hard to get a grip on. But as hospitals reported, as they
11 calculated, they choose to calculate and report it, the
12 available data suggest that uncompensated care has only gone
13 up just a smidgen, even through mid-2005, the results that
14 we have from our own survey we sponsor with CMS. Also
15 there's some shifting from bad debt to charity care.
16 Hospitals are now calling it charity care in response to the
17 pressures that they're under rather than bad debts.

18 MS. DePARLE: That surprises me because the data
19 I've seen would suggest -- a smidgen is several percentage
20 points and that can be, what I've seen at least in the for-
21 profit sector, quite a lot.

22 MR. ASHBY: There's no national data source that

1 would support that several percentage point conclusion.

2 MS. DePARLE: That's interesting.

3 DR. MILLER: Also to your other comment. If that
4 chapter conveys that it's a good thing because it puts cost
5 pressures on them, we'll definitely redraft it to fix that.
6 I'm sure that's not the point that we were trying to convey
7 there.

8 But I also wanted to say, the uncompensated care
9 data that we have is very questionable and we're not certain
10 about it, but we're not seeing that kind of point. But
11 we're not trying to make that point and we can make the
12 uncompensated care issue more clear in the chapter. We
13 certainly weren't trying to convey that.

14 MR. HACKBARTH: Let's move ahead and go on to our
15 next topic. Thank you all.

16 Next we're going to talk about the wage index.
17 This is an informational discussion. It will not include
18 any recommendations.

19 MR. GLASS: Good morning. We're going to take a
20 break now from the update discussions and talk about the
21 wage index for a bit. This is work we introduced in
22 September. Today we'll discuss some of the issues we'll

1 dealing with in that work.

2 We'll look at four wage index issues today. First
3 is the wage index boundary between MSAs and rural areas.
4 This is the so-called wage index cliff problem. Remember
5 that in this system a wage index is calculated for each MSA
6 and then a single wage index for the non-MSA or rural area
7 of each state is calculated, and it's the boundary between
8 those two, the rural area and the MSA that we're going to
9 talk about. We're also going to talk about using the
10 hospital wage index in other sector and whether or not doing
11 so creates some problems. Jeff is then going to talk about
12 variation both over time and within an MSA in the wage
13 index.

14 So the first question, the MSA cliff, this could
15 look like a snow total accumulation expected for the
16 Washington, D.C. area, higher in the northwest suburbs,
17 lower in Virginia. But in fact, this is the 2006 hospital
18 wage index. You can see that it's highest in two counties
19 in Maryland there, Montgomery and Frederick Counties.
20 That's a dark red. Then the rest of the MSA is in pink
21 there. That's the second-highest. Then it goes white, and
22 then blue is the lowest levels down in the rural Virginia

1 areas. The MSA is actually made into two divisions for wage
2 index purposes and that's why you have it higher in two of
3 the counties in the MSA.

4 So the subject is where you have the pink
5 bordering the dark blue there. Where you have that
6 situation, the dark blue is getting about one-third less
7 than the pink areas. That's what the MSA cliff is all
8 about.

9 They've tried several ways of trying to smooth out
10 the cliff and first is the out-commuting approach. That
11 gives counties an add-on if the hospital workers in that
12 county are employed in neighboring higher wage counties.
13 There's two issues with this. One is linked to wage index
14 values. Those are the same for all counties in an MSA. So
15 whether you're county borders a central county or an
16 outlying county of an MSA, the same adjustment is made.

17 The other is that it's computed once every three
18 years and that doesn't reflect changes -- wage data is
19 volatile -- and it can lead to some anonymous results such
20 as Montgomery County in the previous slide actually gets a
21 wage index add-on even though it's already the highest one
22 in the area. That's because when the add-on was computed it

1 was lower than the other ones in the area. So you get some
2 odd results from this one.

3 We can see what it looks like. Montgomery County
4 gets a little better and Culpepper County, which is down
5 there in the lower left part of the slide, turns white
6 instead of blue. So it does fix some of the problems in the
7 sense of smoothing out that boundary by raising some places,
8 but it can also create some other anomalous things like the
9 Montgomery County addition. The cliff now becomes -- to
10 Culpepper it would be about 15 percent instead of 30 percent
11 now.

12 There are a lot of other approaches that have been
13 taken to solve problems in the wage index.

14 Reclassification, for example, has been used. That results
15 now in most North Dakota hospitals are reclassified to
16 Fargo, including one that's over 400 miles away, which would
17 be kind of a broad definition of a labor market area.

18 Also North Dakota, over 30 hospitals are now CAHs,
19 and that's about three times as many as there are IPPS
20 hospitals, I believe. So those CAHs no longer figure into
21 the wage index at all. Their data is no longer counted. So
22 that's another issue with some of this.

1 You also get results like New Hampshire rural
2 floor being higher than the Boston wage index, which would
3 seem unusual. And that some hospitals, to add insult to
4 injury, get an addition for out-commuting as well, in some
5 hospitals in New Hampshire.

6 So when you take all these things together, about
7 one-third of hospitals' wage indexes end up being altered
8 with one or another of these provisions. The limitations of
9 the current wage index system have been recognized but the
10 cure has so far, the ones that are in place, may have some
11 major side effects.

12 The other issue I want to talk about was using the
13 hospital wage index in other sectors. As you can see, most
14 other PPSS now use the so-called pre-reclassification
15 hospital wage index. That's the one before anything is
16 altered, before floors, before reclassification. That's the
17 first picture we saw in the series.

18 Post-reclassification is what the hospital
19 actually gets, and there can be a substantial difference
20 between pre-reclassification and post-reclassification wage
21 indexes. The difference can be as high as 40 percent. For
22 over 100 hospitals, the post-reclassification wage index is

1 over 20 percent higher than for the pre-reclassification
2 wage index.

3 Now what that means is that a SNF and a hospital
4 in the same town can have different wage indexes but compete
5 for the same workers. So one could then construe that
6 providers in other sectors getting the pre-reclassification
7 competing with hospitals for labor could be, theoretically,
8 at a disadvantage. But that would assume that all other
9 payments were accurate in all their ways, financial
10 circumstance were the same, which are fairly large
11 assumptions. But it does raise some question about this
12 system.

13 Now Jeff is going to talk about variation in the
14 wage index system.

15 DR. STENSLAND: One of the things we wanted to
16 look at was how stable is the wage index over time.
17 Basically, does a hospital have its wage index bouncing up
18 one year and then bouncing down the next year? We're
19 somewhat concerned about that. As this chart shows, most
20 hospital had less than a 2-percent shift in their wage index
21 from 2005 to 2006. However, about 7 percent saw their wage
22 index decline by 4 percent or more.

1 Now we looked at these hospitals with a decline in
2 their wage index and saw that over the prior five years on
3 average they had a 5 percent increase in their wage index.
4 Hence, what this large drop was doing was really just
5 bringing them back to where they were five years earlier.

6 Now if we look at the other side of the chart and
7 look at the winners we see that roughly 8 percent saw their
8 wage index increase by more than 4 percent. In contrast to
9 the declines in wage index, many of the shifts upward in
10 wages are not offsetting earlier year losses. These often
11 represent net gains to the wage index, in some cases from
12 hospitals being reclassified into a higher wage index area.

13 Due to these reclassifications, we see that the
14 average wage index over time is increasing slightly.

15 Historically, CMS has paid for the cost of increasing wage
16 indexes with a budget neutrality adjustment to all
17 hospitals' base payment rates. However, the MMA has not
18 followed this precedent. The new wage adjustment enacted as
19 part of the MMA, that's the 508 adjustment and the out-
20 commuting adjustment, those are both not budget neutral. So
21 those two new adjustments add new money into the system.

22 To summarize, we have some large declines that we

1 occasionally see in the hospital wage index, but this is
2 usually due to some temporary noise in the data. We have
3 some large increases that we sometimes see due to
4 reclassifications and these are often permanent, and in some
5 cases these reclassifications can add new money into the
6 system.

7 Now in addition to examining one-time increases or
8 one-time decreases in the wage index, we also wanted to
9 examine how often hospitals experience persist large
10 increases or persistent large decreases in their wage index.
11 We found that only 18 hospitals experienced more than a 2-
12 percent increase in their wage index for three straight
13 years. These hospitals often benefitted from
14 reclassification in one of those years.

15 We also found 16 hospitals that experienced more
16 than a 2-percent decline in their wage index for three
17 straight years. These declines are often partially
18 explained by the new MSA definitions that went into effect
19 in 2005. What these new MSA definitions did is, in some
20 cases, they moved higher wage hospitals out of a market,
21 causing a decline in the wage index for hospitals that
22 remained in that market.

1 The lesson I get from this analysis is that the
2 long-term trends in a region's relative wages tend to move
3 at a very slow pace. We do not see year after year large
4 monotonic increases or larger monotonic decreases in
5 hospital wages.

6 Now David earlier had talked about a rural-urban
7 cliff. I'm going to talk a little bit about wage variation
8 within an MSA. As an example, we looked at the Washington,
9 D.C. MSA which is quite large, the picture that David had up
10 earlier. This slide shows the variation in nursing wages
11 within the Washington, D.C. MSA. In the center of the
12 market, which is the actual city of D.C. and the adjoining
13 Fairfax and Arlington Counties, the average RN earned \$24
14 per hour in 2000. In the second ring of counties, which is
15 roughly an hour drive outside of the center of the city,
16 nurses earned an average of \$22 per hour. In the outer ring
17 of the MSA, which stretches into West Virginia, the average
18 RN earned \$19 per hour.

19 So what we see here is while wages within the MSA
20 vary by roughly 20 percent from the center core to the outer
21 edge, hospitals in all parts of the MSA receive wage index.
22 Now this problem has been pointed out earlier by the GAO,

1 and CMS chose not to change the wage index because there was
2 a great difficulty in trying to build consensus on how to
3 change it. This raises the question when we look at
4 alternatives to the current wage index, how do we plan to
5 evaluate the attractiveness of the different alternatives?

6 In examining alternatives to the wage index we
7 plan to examine, first, how well does each alternative
8 predict costs?

9 Second, how well does it address the boundary
10 problem that David talked about and in the inter-MSA problem
11 that I talked about? Does it reduce year-to-year volatility
12 in the wage index? Would it be simple to administer and for
13 people to understand? And would it create an accurate wage
14 data that could be used outside of the hospital sector?
15 Meaning, would it also improve the accuracy of the wage
16 index for other sectors such as SNFs and home health?

17 We'd now like to hear your questions and comments.

18 MR. HACKBARTH: To trick is that those are in
19 conflict, potentially those objectives, and there are trade-
20 offs to be made.

21 DR. WOLTER: I guess the questions I would put on
22 the table related to this are, what does this mean in terms

1 of the impact once the wage index drives a certain update?
2 For example, what percentage of hospitals are greater than
3 one for their wage index? I think you said about one-third
4 are reclassified. And of those that are reclassified, are
5 they generally reclassified into a one or higher? Is it
6 theoretically even possible, if you're not above one or
7 you're not reclassified, to ever receive a market basket
8 update? I'd be interested to know that.

9 DR. SCANLON: This is not market basket. This is
10 geographic.

11 DR. WOLTER: But once the wage index is applied it
12 does affect your update, correct?

13 MR. HACKBARTH: It affects the base level of
14 payment as opposed to the update. It would interact with
15 the update. From time to time I've heard a hospital say, my
16 wage index went down and that offset all or part of the
17 update. But analytically, in terms of the structure of the
18 payment system, they're distinct things. One is a base
19 payment issue, the other is an annual increase issue.

20 DR. WOLTER: But my basic question remains the
21 same, from year to year to year can we get any sense of the
22 different profiles of -- do people tend to fall consistently

1 at 1.0 and above, and how does that affect then their base
2 payment? Institutions that are reclassified, how does that
3 affect their payment year-to-year? And then the group that
4 is that neither category, how does that affect them?

5 The basic question is, is it possible to get an
6 analysis of the impact of this on payment in terms of the
7 profiles of the institutions affected? It's just a
8 question. I'd be interested in data if we could get it.

9 DR. STENSLAND: I think we can do that.

10 Naturally, when you have the reclassification that increases
11 your wage index, your payments go up. Historically, what
12 then would happen would be they would, in the end then, make
13 a little budget neutrality adjustment and take everybody
14 down a touch to compensate for the fact that your payments
15 went up by 8 percent, say, when you moved out from a rural
16 area into the MSA.

17 But these new adjustments, like this new one-time
18 reclassification, which is about \$300 million a year, that
19 can give some pretty significant update increases in
20 payments to people, on the order of 8 to 10 percent and then
21 that boosts them up for three years with this one-time boost
22 of money. Then at the end of the three years it's scheduled

1 to go away, as Jack talked about earlier.

2 MR. GLASS: If you look at this graph you can see
3 that those getting over 3 percent, so the ones -- it's that
4 7 percent minus 4 or less that I think you were concerned
5 about actually getting the change in wage index that
6 outweighed their update, correct? So that's how big that
7 group would be in that particular year.

8 DR. MILLER: I'm not sure I'm following this, so
9 if we're going to do something I want to see if I get it.

10 It's not so much the net impacts that you're
11 interested in. You're interested in -- I'm asking -- if you
12 could take a look at the hospitals, classify them into some
13 kind of typology, people who generally stay in the same
14 place, people who got reclassified, people who are above one
15 and move around, or stay below one, and see over some time
16 period what the effect has been on their base payment. Is
17 that the question that you're getting?

18 DR. WOLTER: I think in a nutshell I'm just trying
19 to understand the magnitude of the issue that we're dealing
20 with in terms of how is it affecting payment and can we
21 break it out in --

22 MR. MULLER: You have it there. I mean, the

1 multiplication is obviously transitive so you have 20 and 15
2 and five and seven, so you have almost 50 percent get less
3 than the update because of the --

4 DR. REISCHAUER: Remember you multiply -- this
5 only applies to the labor part of total costs, so you --

6 MR. MULLER: So 70 percent.

7 DR. REISCHAUER: 50 percent, I think, 52 percent.

8 DR. MILLER: So your point is relative to the
9 update, Nick? That was what your question was driving at.

10 DR. WOLTER: Yes, I'm just trying to understand
11 the magnitude of the distributional impact that this system
12 has, which I don't understand exactly from these numbers.

13 MR. HACKBARTH: The magnitude of the impact of the
14 year-to-year changes, or overall the magnitude of the
15 redistributional impact of the wage index? The latter?

16 DR. WOLTER: The latter, but probably both.

17 MR. HACKBARTH: There's a wide range of wage
18 indexes from --

19 DR. STENSLAND: 0.6 to 1.5, something like that.

20 MR. HACKBARTH: 0.6 to 1.5, and it's applying to
21 60-some percent of the rate -- close to 70 percent now of
22 the rate.

1 MR. GLASS: Yes, the labor share is about 0.7 now
2 almost for most --

3 MR. HACKBARTH: So it's a big variation in the
4 starting point in the payment system.

5 DR. SCANLON: But it's meant to level the playing
6 field, and even the changes in the negative are supposed to
7 reflect the fact that your labor market has changed and your
8 costs have gotten cheaper. Our problem is, how good is the
9 index relative to what's happening in the labor market that
10 the hospital is facing, and we've got potential significant
11 issues there.

12 DR. REISCHAUER: Can you remind me where they get
13 the basic data from, nurses' salaries, lab technicians'
14 salaries and all of that? Are these from --

15 MR. GLASS: They don't do it that way. They take
16 the average wage reported by the hospital in the hospital
17 cost report and compare that to the national average.

18 DR. REISCHAUER: Undifferentiated by occupation?

19 MR. GLASS: The occupational mix problem -- I
20 didn't bring it up today but they are trying to deal with
21 that.

22 MR. HACKBARTH: The answer is, yes, that it hasn't

1 adjusted --

2 MR. GLASS: Right now they're adjusting 10 percent
3 of it for the occupational mix adjustment, but the current
4 occupational mix adjustment is somewhat questionable so they
5 just issued a proposal to do a new survey that's going to
6 collect occupations, their hours and their wages for each
7 hospital. They're going to start from that and see if they
8 can do another job on the occupational mix adjustment,
9 because they lost a case that said they should be
10 occupationally mix adjusting 100 percent of it.

11 DR. MILLER: But you've put your finger on one of
12 the fundamental issues we're raising with this analysis
13 which is, where should the data come from? That's one of
14 the issues that we're going to be looking at. If that
15 wasn't clear in this conversation, we should make it clear.
16 It's not just messing around with the hospital-reported data
17 and can you make this better? Theirs is a fundamental
18 question of do you just go outside it and start working more
19 with Census data and trying to get that to make these
20 adjustments.

21 MR. GLASS: To be specific, we are looking at
22 alternatives where you would use BLS and Census data which

1 would reflect not only hospital employment but all
2 employment for those occupations in the market area. We
3 think that might help out and also make it more applicable
4 for other sectors.

5 DR. REISCHAUER: Imagine that we had perfect
6 occupational data and it was collected by hospitals and you
7 could figure out what the average was for each county. Why
8 would you want to do, in and out, any kind of adjustment at
9 all? This would be the market. This is what people are
10 paying. Why should there be an adjustment at all?

11 MR. HACKBARTH: The county may not be the true
12 market.

13 DR. REISCHAUER: We wouldn't have to do it by
14 county. You could do it by zip code or something like that.

15 MR. GLASS: Given a reasonable approximation of
16 the market and good data that would be the hope, that you
17 wouldn't have to have reclassification, out-commuting and
18 all of the other things that have been created to deal --

19 DR. REISCHAUER: But what is the logic for the
20 out-commuting?

21 MR. HACKBARTH: That we don't have a reasonable
22 approximation of the real market.

1 DR. REISCHAUER: But the reason we don't is
2 because we don't have the disaggregated information of hours
3 by occupation for the entity, not that --

4 DR. MILLER: It's more than just that. It's the
5 data and the unit you're looking at. So if you report for a
6 given hospital and this hospital says, I know these are the
7 wages that I'm paying but I'm competing against somebody who
8 can pay more and people are leaving my -- this is the
9 argument.

10 DR. REISCHAUER: But then the next year they've
11 had to pay more and the data you collect is higher, so in a
12 sense you've been unfair for a year or something like that.
13 But it's the most accurate measure of what the market
14 actually is.

15 DR. MILLER: I understand that. I'm just telling
16 you what drove the out-commuting change in the law.

17 DR. STENSLAND: I think we're exactly thinking
18 about looking at what you're talking about, because there's
19 this cliff that David talked about and you can address it
20 two ways, one with out-commuting, or you could just look at
21 the level of wages in each county and then do some smoothing
22 between the counties and you could address the problem that

1 way. So there's definitely another way to address it.

2 MR. DeBUSK: In the rural setting there's another
3 situation that has evolved or perhaps it's been there to
4 some degree all along, and that's supply and demand. Let me
5 give you an example there in the Appalachians. In
6 Middlesboro, Kentucky a nurse can start at that local
7 hospital for -- within six months you're at \$22 an hour.
8 Folks, this is in rural, rural America. There's very little
9 supply. So you've got these small hospitals that are really
10 pressed to make it and they're paying wages equal to
11 Washington. This is going on because of supply and demand.
12 This is another extreme, in one sense, but probably is very
13 realistic throughout all those mountains. So you've got
14 people here that are really going to struggle with those
15 kinds of costs, and it goes throughout the whole spread of
16 professional people.

17 DR. SCANLON: The data on slide 10 which had you
18 mentioned were from the GAO report, and this is the
19 Washington MSA and that third ring is part -- the West
20 Virginia counties are there. The actual wages being paid in
21 those hospitals are \$19 compared to in D.C. we're paying
22 \$24. But the West Virginia hospitals are benefitting.

1 If you look at the MSAs, except for New York City,
2 the MSAs are dominated by the hospitals in the central
3 cities. So therefore, the outlying hospitals all benefit
4 from the higher wages in the central city even though, as
5 Bob's point, they're not paying those wages. Their staffed
6 and this is what they actually paid was the \$19 but they're
7 getting something closer to a wage index based upon \$24. In
8 your world, where you had more realistically defined labor
9 markets everybody would be getting something more comparable
10 to what they actually pay.

11 DR. STOWERS: Bill, you lose me when you say they
12 benefit because being on the board of a hospital that was
13 about 60 miles out and in the third ring, all of our supply
14 and demand thing that Pete was talking about was willing to
15 drive, so our need got a lot worse, so we had to pay more
16 than the \$19. So I'm trying to figure out how we --

17 DR. REISCHAUER: But if you do it will be
18 reflected in the index.

19 DR. SCANLON: In the data. But the people in West
20 Virginia aren't.

21 DR. STOWERS: Not for that individual hospital
22 though.

1 MR. HACKBARTH: Everybody's going to face the same
2 supply and demand within the geographic area, unless you're
3 talking about --

4 DR. STOWERS: I just want to reiterate, and
5 everybody's aware of the Congressional thing, it is very
6 much a chicken and the egg because you're sitting on that
7 board and something makes up 60 or 70 percent of your
8 overall budget then it's not like that money is going to
9 come from -- so you're kind of trapped and an ability to --

10 MR. HACKBARTH: There are issues about a lag in
11 the data. Wages quickly spike up, the data aren't collected
12 continuously, and so there can be a temporary problem due to
13 that. That's a given.

14 But I think Bill's point is that hospitals are
15 getting reclassified into areas that give them wage indexes
16 that are really much higher than the actual wages that
17 they're paying. That happens to, and it's happened in a big
18 way.

19 DR. SCANLON: And there's a group of hospitals
20 that benefit without reclassification because they are on
21 the fringes of an MSA. They didn't fall off the cliff.
22 They're on this side of the cliff and yet they're really a

1 long way from the central city where the wages are so much
2 higher.

3 MR. HACKBARTH: What makes this area challenging
4 is there are lots of data issues in trying to get the right
5 data and then in formulating the right adjustments. We've
6 got these trade-offs among competing, potentially
7 conflicting goals and we've got to figure out what the right
8 strategy is for that. Then the third piece is, politically
9 it's very complex, especially in an era where we've had a
10 lot of people reclassified into areas where their payments
11 are much higher than their actual wages, they're going to be
12 very reluctant to give that up. So this is complicated
13 every way you look.

14 Any other questions or comments on wage index
15 research?

16 DR. REISCHAUER: There's one thing to point out
17 and that is for every person who's getting, in a sense, too
18 much, there's somebody who's getting too little because of
19 the way this thing works out.

20 MR. GLASS: Except with the recent changes where
21 we're trying to strive for everyone to get above average.

22 MR. HACKBARTH: That used to be the rule of the

1 game. No more.

2 We are at the public comment period on the morning
3 session.

4 Carmela, before you begin let me do my usual
5 little spiel. We want to have as many comments as possible
6 and so we urge you to keep them brief and avoid repetition.
7 Feel free to come up and say that you agree with a previous
8 speaker. That's fine. Go ahead, Carmela.

9 MS. COYLE: It looks like it will be short by the
10 size of the line. Carmela Coyle with the American Hospital
11 Association.

12 Wanted to say that we appreciate the Commission's
13 efforts to again begin to address this issue of efficiency
14 which is clearly a very difficult, a very challenging one.
15 It really is difficult to assess other than on a case-by-
16 case basis. But would urge some caution in the analysis
17 that was presented this morning about throwing out the one-
18 fifth or the 800 high-cost hospitals, perhaps without a
19 better understanding of what's driving those high costs.

20 Layer on top of that, I think what you're looking
21 at and what was presented in terms of expected 2006 Medicare
22 margins, not only expected cost increases, whether it's

1 clinical technology, information technology, issues around
2 Sarbanes/Oxley compliance, whether it's projected payment
3 cuts. I heard staff suggest that in those calculations were
4 the geographic reclassification changes that are expected.
5 Didn't hear a specific mention of the transfer changes that
6 are also coming down the pike to the tune of reducing
7 hospital payments by \$1 billion in 2006, another \$1 billion
8 in 2007. It may be in there; just wasn't clear.

9 MR. HACKBARTH: It is.

10 MS. COYLE: Thanks, that's very helpful. But I
11 guess the bottom line, taking a look at some of the data
12 that was presented this morning for the three for-profit
13 chains, about 300 hospitals, where costs were increasing at
14 5 percent, one might argue that that's a set of hospitals
15 that has an even stronger incentive to maintain, reduce
16 costs where they can. Yet juxtapose that with the proposed
17 recommendation, market basket minus half the productivity
18 increase, which would yield about a 3 percent update. So
19 you've got 5 percent costs and at least in your discussion
20 today a potential for only a 3 percent update. I think the
21 suggestion is that payments are inadequate. Even as you
22 project it out, you're looking at negative or zero margins.

1 Would just ask you to reconsider a higher recommendation at
2 your January meeting.

3 A second issue is on the outpatient hold harmless.
4 Would strongly encourage this commission to extent that hold
5 harmless for another year. Basically, a recommendation you
6 made last year. As you do your work over the next month
7 there are about some 600 hospitals that benefit today and
8 are assisted by that hold harmless. Under a 25-mile limit
9 test only about 150 . I think it's that better
10 understanding of who are those 450 hospitals in the middle.

11 Just one story, because your conversation went to
12 this. Many of the hospitals that have been changing to
13 critical access hospital status have had to squeeze down
14 under that 25-bed limit. Many have done so by discontinuing
15 their OB/GYN and their delivery services. It's those other
16 450 rural hospitals that are the ones left delivering the
17 babies in this area. So the financial struggle for those
18 critical access hospitals, the choices they've made, I think
19 we have broader societal benefits by still being able to
20 deliver babies within a 50 or 60-mile radius those other
21 hospitals. Just encourage you to look at those 450.

22 Thanks.

1 MR. HACKBARTH: All right. We will go to lunch
2 and reconvene at 1:30.

3 [Whereupon, at 12:09 p.m., the meeting was
4 recessed, to reconvene at 1:30 p.m., this same day.]

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AFTERNOON SESSION

[1:39 p.m.]

2

MR. HACKBARTH: While people are taking their
seats, could I have your attention?

4

I want to just talk for a second about the
weather. Since we don't have anything else to talk about,
let's talk about the weather. As everybody knows, the
forecast is for snow tonight. Last I heard was two to four
inches in the District, four to six. I've got one to three
over here. Do I have another offer? The probability of
accuracy is -- who knows?

11

At any rate, I think we would be well-served if we
just think about possibilities for tomorrow.

13

Even if there's a relatively small amount of snow,
it would not be unusual for the Federal Government to either
close its offices or have a delayed opening, something like
that, or a liberal leave policy.

17

Barring an unforeseen level of snow, we are
planning on having our meeting tomorrow, our public meeting.
So that's a message for Commissioners and staff and the
public audience. In a minute, Mark, I'll let you address
the staff issue if you want to do that.

22

So don't be put off by what you see on the morning

1 news. Try to make it here with -- obviously safety is the
2 first priority. If it's so bad as to compromise that, don't
3 come.

4 But we're going to do whatever we can to have our
5 meeting tomorrow for the simple, very practical, reason that
6 we don't have any alternative. We can't reschedule and
7 we've got work that we've got to do and now the deadline is
8 near, with January quickly upon us.

9 Mark, do you want to say anything about staff?

10 DR. MILLER: No. The only thing I was going to
11 say for staff was exactly what you said. Try and come
12 unless it compromises your safety.

13 MR. HACKBARTH: Any questions from Commissioners
14 on that?

15 DR. KANE: Is there a number you can call?

16 MR. HACKBARTH: Mark at home. Starting at 3:00
17 a.m., Mark will take calls.

18 DR. MILLER: That number is 555-1212.

19 In all seriousness, usually what I do in these
20 situations, although I've forgotten the number since last
21 year, there's a number I call to find out what the Federal
22 Government is doing. And then we had a system to enter the

1 phone for staff to call at MedPAC. I can give you, at the
2 end of my meeting, my cell phone.

3 But I think the mission here is even if the
4 Government is going to be delayed or liberal leave, or
5 whatever it is, I think we're leaning forward to do this.

6 MS. DePARLE: Is the building going to be open
7 tomorrow?

8 DR. MILLER: That's a good question. Annissa, can
9 you check on this?

10 MR. HACKBARTH: Let's turn now to the agenda,
11 which has us moving on to assessment of payment adequacy for
12 dialysis.

13 MS. RAY: Good afternoon. Today's presentation on
14 outpatient dialysis is composed of three parts. First, I
15 will provide you information to support your assessment of
16 the adequacy of Medicare's payments. Second, I will present
17 last year's recommendation about updating the composite rate
18 -- that's the payment rate for dialysis treatment --
19 updating the composite rate for calendar year 2007. And
20 third, I will briefly update you with new information about
21 Medicare's payment for drugs in 2005 and provider's ability
22 to purchase drugs.

1 The first part of this presentation focuses on
2 payment adequacy. The factors of payment adequacy are
3 presented on this slide. Today I will be focusing on
4 beneficiaries' access to care, changes in the volume of
5 services, and Medicare's payments and costs in 2006.

6 Recall in October we discussed providers' capacity
7 to meet patient growth, changes in quality of care, and
8 providers' access to capital. I just want to briefly recap
9 those results.

10 First, providers appear to have sufficient
11 capacity to care for patients as measured by the growth of
12 facilities, hemodialysis stations and patients.

13 Moving on to dialysis quality, it is improving for
14 some measures like dialysis adequacy and patient's anemia
15 status. One measure, nutritional status, has showed little
16 change over time. Nancy-Ann, you raised a concern about
17 this lack of improvement in October. After considering this
18 issue in the chapter, we include a statement strongly urging
19 the Secretary to include malnutrition as one of the initial
20 measures used to link payment to quality.

21 Regarding access to capital, indicators such as
22 recent financial information, access to private capital to

1 fund acquisitions, and evidence about the increase in
2 dialysis facilities suggest it is adequate.

3 Regarding beneficiaries' access to care, we began
4 to talk about this in October and we see that it is affected
5 by certain local issues. In addition, the proportion of
6 providers offering in-center hemodialysis -- nearly all --
7 and peritoneal dialysis -- about 45 percent -- has remained
8 constant over the past five years. In the back of the
9 chapter that was enclosed in your mailing materials I have
10 included a new section on some of the factors that may be
11 affecting the use of home dialysis.

12 Now let's move on to some new information for you
13 to consider.

14 Last year we found that facility closures may be
15 disproportionately occurring in areas where a higher
16 proportion of the population is African-American. However,
17 this finding was derived from an analysis of area level
18 data. Area level analyses cannot speak about the patients
19 treated by a specific facility.

20 Therefore, we conducted a new analysis that linked
21 patients to the facilities that cared for them. We divided
22 facilities into three groups: those that newly opened in

1 2002, those that closed in 2002, and those that remained in
2 business in both years. The objective here was to assess
3 whether certain beneficiaries are disproportionately
4 affected by closures.

5 In addition, we also wanted to see whether new
6 facilities are disproportionately caring for certain groups
7 versus other groups.

8 I'd like to highlight three results. First, the
9 characteristics of the patients treated by facilities that
10 closed and those that newly opened were similar. About a
11 third of the patients were African-American. Nearly half
12 were female. And nearly one quarter were elderly and about
13 40 percent were dual eligible.

14 In 2002, providers' capacity to furnish care
15 increased on net by 131 facilities and about 2,000
16 hemodialysis stations. Third, facilities that remained in
17 business in both years treated a greater proportion of
18 patients that were African American and dually eligible for
19 Medicare and Medicaid. These results together suggest that
20 beneficiaries should not be experiencing problems accessing
21 needed care.

22 I'd like to point out a couple more results we

1 found from this analysis. First, the closures of the
2 facilities in 2002 may be linked to their profitability,
3 size and economies of scale. For example, the Medicare
4 margin for the closed facilities was negative 5 percent in
5 2001 but was 4.1 percent for the facilities that remained in
6 business.

7 Second, closures do not seem to appear to affect
8 rural beneficiaries disproportionately. About a quarter of
9 facilities are located in rural areas, looking at closed
10 facilities, newly opened facilities and facilities that
11 stayed in business.

12 Finally, the share of Medicare treatments was
13 somewhat lower for newly opened facilities at about 74
14 percent, compared to their counterparts which was between 78
15 percent and 79 percent. Some dialysis providers have
16 informed MedPAC that the payment rates of commercial payers
17 exceeds that of Medicare's and Medicaid's rates and the
18 difference in the payment rates between the commercial
19 payers and the government payers may be influencing their
20 decision about where to open facilities.

21 In conclusion, the findings from this analysis and
22 our other analyses that we presented in October suggest that

1 beneficiaries should not be experiencing systematic problems
2 in accessing care.

3 We looked at trends in the volume of services
4 furnished to patients. We look at it in terms of changes in
5 annual spending between 1996 and 2004 because that is the
6 unit that is common between composite rate services and
7 separately billable dialysis drugs. Total payments have
8 increased about 8 percent per year for composite rate
9 services, 13 percent per year for erythropoietin and 18
10 percent per year for other drugs.

11 To put these growth results in perspective for
12 you, dialysis patients increased roughly by about 5 percent
13 per year during this time and drugs share of total dollars
14 for a given facility has increased from about 31 percent in
15 1996 to 42 percent in 2004.

16 Let's move to our analysis of Medicare payments
17 and costs. We looked at providers' Medicare allowable cost
18 for the most recent year that data is available. For this
19 analysis, I used 2003 cost reports, not 2004. Let me
20 explain to you why I did not use 2004 cost reports. In 2005
21 CMS required providers -- dialysis facilities -- to begin to
22 file their 2004 cost reports electronically. By all

1 accounts, they did so. However, the fiscal intermediaries
2 are still processing many of these 2004 cost reports. The
3 file that we received from CMS did not include a sufficient
4 number for us to proceed with an analysis using the 2004
5 reports. Thus, we are using 2003 data.

6 So our results here show little change from what
7 we found last year using 2003 cost reports. Costs per
8 treatment grew roughly 2 percent annually between 1997 and
9 2003. In the most recent year, that is between 2002 and
10 2003, costs decreased by about 1 percent.

11 Between 1997 and 2003 there is some variation in
12 cost growth, ranging from 0.2 percent for low-growth cost
13 providers to 3.7 percent during this time period.

14 Moving to the audit factor. Our margin analysis
15 is based on costs being Medicare allowable. That is why we
16 have considered and continue to consider how CMS's audit
17 efforts affect the level of costs. 2001 is the most recent
18 reports that have been audited. The most recent 2003 file
19 we have shows that 20 percent of these reports have been
20 settled with an audit. For facilities whose cost reports
21 were settled by an audit, the cost per treatment for
22 composite rate services decreased from about \$144 to \$137.

1 By contrast, their drug costs remained essentially the same.

2 Therefore, we determined the Medicare margin by
3 applying an adjustment of 94.5 percent, that is the ratio of
4 136 divided by 144, to the cost of composite rate services
5 for facilities whose cost reports have not been settled yet
6 by CMS.

7 So here is the Medicare margin for both composite
8 rate services and dialysis drugs. It was 5.5 percent in
9 2000, 2.4 percent in 2003. We project it will be negative
10 2.9 percent in 2006.

11 If, however, we assume that providers will achieve
12 a 6 percent margin on average from dialysis drugs in 2006,
13 and they will be paid average sales price plus 6 percent in
14 2006, then we project the margin to be negative 1.7 percent.

15 To give you some feel for the variation around the
16 margin, in 2003 it ranged from a negative 0.3 percent for
17 nonprofits to 3.7 percent for facilities in one of the four
18 national chains. They compose about 70 percent of all
19 treatments.

20 So now the second part of our update process is to
21 consider the cost changes in the payment year we are making
22 a recommendation for, that's 2007. Here CMS estimates their

1 market basket increase would be 3.2 percent and our
2 productivity growth factor is 0.9 percent.

3 I'd like to start your discussion about payment
4 adequacy and updating the composite rate with last year's
5 recommendation, and that is that Congress should update the
6 composite rate by the projected rate of increase in the ESRD
7 market basket less half the adjustment for productivity
8 growth. Again, this will be for calendar year 2007.

9 Spending implications: this will increase
10 spending over the baseline. There is no provision in
11 current law to update the composite rate in 2007.

12 Updating the composite rate will maintain
13 beneficiaries' access to quality care. It will increase
14 beneficiaries' copayment, as well as increase providers'
15 payments.

16 Finally, before you begin your discussion about
17 payment adequacy, I'd like to just very briefly talk about
18 the policy change in how Medicare paid for dialysis drugs in
19 2005. This is the first year that Medicare based payment on
20 acquisition costs. Providers were paid an average
21 acquisition payment. Some stakeholders were concerned
22 providers might not be able to purchase the drugs below

1 Medicare's payment rate. MedPAC acquired pricing
2 information for the top 10 dialysis drugs from a commercial
3 data source. We tracked trends in the average purchase
4 price and price variation from the first to the third
5 quarter of 2005. Our results suggest that in 2005 the
6 average purchase price of most drugs used by dialysis
7 patients decreased and that freestanding dialysis providers
8 could generally purchase drugs at less than Medicare's
9 payment rate in 2005.

10 That concludes my presentation. I'll put the
11 draft recommendation up and look forward to your discussion.

12 MR. HACKBARTH: For those who weren't here this
13 morning, let me just say a word about the draft
14 recommendation. The draft recommendation is what we
15 recommended last year for the update for dialysis
16 facilities. And so I would urge people not to read too much
17 significance into that. It is simply a carryover from last
18 year.

19 Nancy, could I ask a question about the table on
20 page eight? I need to get my thinking straight here because
21 I'm used to our old approach where we used to have the
22 margin based on the composite rate alone and then the margin

1 based on the composite rate plus the drug expenditures, and
2 there have been changes in the rules of the game.

3 When you introduced this table, I thought that you
4 said these are the margins on the composite rate. This
5 includes both a composite --

6 MS. RAY: This is the aggregate margin for
7 composite rate and dialysis drugs.

8 MR. HACKBARTH: So this is sort of the combined
9 margin?

10 MS. RAY: Yes.

11 MR. HACKBARTH: And then say one more time the
12 difference between the 1.7 and the 2.9.

13 MS. RAY: That negative 1.7 assumes that providers
14 can achieve a 6 percent payment margin on drugs.

15 MR. HACKBARTH: Another words, if they can get it
16 at the ASP?

17 MS. RAY: Yes. The negative 2.9 does not make
18 that assumption.

19 MR. HACKBARTH: What does it assume about the
20 level at which they can buy the drugs?

21 MS. RAY: It assumes the normal cost growth, which
22 we assumed to be at the PPI in 2006.

1 MR. HACKBARTH: Okay. Questions, comments?

2 MS. DePARLE: Nancy, thanks for the more detailed
3 explanation about the data and the lag in it.

4 It sounds like, from our conversation, that we
5 won't have 2004 data in time for you to do your analysis for
6 this year. Is the glitch that occurred something that we
7 understand has now been corrected so that for coming years
8 we'll have better data?

9 MS. RAY: That's a good question. We will follow
10 up with that.

11 MS. DePARLE: This was supposed to make it better
12 by enabling the providers to do this.

13 MS. RAY: It was. We will follow up and get back
14 to you on that in January.

15 MS. DePARLE: You put up your slide about the
16 audit factors, is what you're calling it I guess, which
17 we've had discussions about before here. Will the new way
18 that the FIs are collecting the cost reports do anything to
19 make that easier or unnecessary? This is an extra step that
20 you take in analyzing the data; correct? Because you've
21 determined that there is a discrepancy between allowable
22 costs and what some of the cost reports show that facilities

1 are actually claiming.

2 Will this new way of collecting the data do
3 anything to make that less necessary or not?

4 MS. RAY: I don't think so. I don't think so.

5 MS. THOMAS: My understanding from the
6 transactions between Nancy and the person at CMS is simply
7 that they're submitting it electronically. There's no
8 difference to the quality of data, it's just all uploading
9 it electronically.

10 MS. RAY: Yes.

11 DR. SCANLON: I was going to respond that there
12 are other providers. It's been something that CMS and HCFA
13 have done in the past, in terms of doing an audit and making
14 an adjustment to construct the PPS rates. Because there is
15 always a problem of --

16 MS. DePARLE: I'm aware of that. I don't know
17 that it's a step that we take with every provider, though;
18 is it? This is something that's just for dialysis where
19 MedPAC applies an audit factor, and that's what I've
20 objected to in the past. I'm certainly familiar with
21 audits.

22 DR. MILLER: The reason that we do here is that

1 actually somebody went through the exercise early on and
2 estimated an audit factor here. And that's what we've been
3 kind of working off of and doing some more recent estimates
4 of our own.

5 MS. RAY: Just to follow up, ProPAC originally
6 looked at the difference between cost reports that were
7 audited versus those that were not. And then I looked at a
8 fair number of the 1996 cost reports were audited and that's
9 what we had used up until last year when we saw that last
10 year 11 percent of the 2001 cost reports were audited. This
11 year we found that of our 2001 batch, 20 percent are now
12 audited.

13 MS. DePARLE: That's better. But the problem I
14 have with it is that it's very lagged. We've talked here
15 before about the slight percentage of reports. It sounds
16 better, at least, 20 percent. But the slight percentage
17 that are audited, the lag in it disturbs me, having it apply
18 from 2001 to today across the board.

19 My main concern is that if we're going to do this
20 -- I've said this in previous years -- if we're going to do
21 it, we should do it for all sectors, not just for dialysis.

22 DR. MILSTEIN: A couple of questions. The first

1 is partly a carry forward of momentum from the pre-lunch
2 discussion.

3 Am I right, have we or have we not previously
4 profiled dialysis providers in a manner similar to what we
5 were shown for hospitals? So we can begin to sort of think
6 about this problem using the MMA reference point of what an
7 efficient dialysis facility needs to generate positive
8 Medicare margins? Have we done that?

9 I guess the even more important question is if we
10 have done it, does it generally show that there is a
11 substantial slug, a segment of this industry, that has
12 robustly positive Medicare margins?

13 MS. RAY: We did an analysis several years ago in
14 which we looked at providers' costs and their quality of
15 care. There we found that higher costs are not necessarily
16 associated with better levels of quality. We have not
17 specifically tied that analysis here into the update
18 analysis.

19 I guess the other thing that we did show back in
20 our June report is that dialysis quality, at least for
21 dialysis adequacy and anemia status, doesn't vary that much
22 between the different provider types.

1 The third piece of information we do know in all
2 of this -- I guess the short answer to your question is we
3 have not integrated in this. But we also know that the more
4 efficient providers in this group tend to be those
5 affiliated with the four largest chains.

6 DR. MILSTEIN: My second question is -- and I
7 guess this pertains to this but it also relates to the prior
8 discussion. If we believe the IOM report, that this is an
9 industry -- I don't mean the dialysis industry only, but the
10 health care industry -- is an industry that is not really
11 what, benchmarked against other industries, we would deem to
12 be lean in the manufacturing sense, what is the rationale
13 for suggesting that the subtraction for the productivity
14 factor be half of what's being achieved in other industrial
15 sectors?

16 An argument could be made since the baseline is
17 less efficient, it should be double.

18 MR. HACKBARTH: The rationale in this case is that
19 in dialysis last year, as was true in hospitals, we had
20 indications that the margins had gone from being positive to
21 being negative. And so cutting the productivity adjustment
22 in half was a way of easing off the pressure in view of that

1 development.

2 DR. MILSTEIN: I'll stop. The linkage to my prior
3 question would be if we were to determine that a very
4 substantial fraction of the industry has positive Medicare
5 margins. Despite this equilibrium, that might reduce the
6 rationale for cutting the productivity expectation in half.

7 MR. HACKBARTH: Right, and in keeping with the
8 efficient provider mandate that Congress gave us in MMA, in
9 this sector as in others ultimately we want to be looking
10 not just at average margins but try to hone in in various
11 ways on what that most efficient provider -- considering
12 both cost and quality -- is producing, and start gearing our
13 recommendations to that. That is definitely the objective.

14 Nancy you, in your initial response to Arnie,
15 alluded to our earlier research, didn't you, about the
16 relationship between cost and quality. And we found that
17 there was not a direct relationship between higher cost and
18 higher quality.

19 Although, as I recall, that analysis focused on
20 the composite rate services as opposed to the larger bundle;
21 is that correct?

22 MS. RAY: Right. We did it both ways. We looked

1 at the composite rate. Then we put composite rate and drugs
2 together. And there we found that it was an inverse
3 relationship.

4 Part of that reason could be due to patient case
5 mix, which we made some adjustment for. But it may not have
6 been as complete as necessary.

7 MR. HACKBARTH: Let me just play that back, to
8 make sure I understood correctly. When we added in the
9 drugs, you're saying that there was actually lower cost
10 institutions were associated with higher quality but the
11 residual concern about that is whether we had adequately
12 adjusted for the case mix difference.

13 Other questions or comments on this?

14 MR. DeBUSK: [off microphone] Nancy, I'm going to
15 ask you a question about a statement the industry makes and
16 I'd like to hear your comment. They say access to care has
17 very little to do with Medicare economics. If it were not
18 for commercial payers who grossly subsidize the losses
19 incurred by treating Medicare beneficiaries, there be a
20 major issue in access of Medicare beneficiaries. Is that
21 true or false?

22 MS. RAY: I think we see that on average the

1 payment rate from commercial providers is greater than
2 Medicare and Medicaid's payment rate. I think it's
3 important to recognize -- and that for about 25 percent of
4 new ESRD patients, Medicare is the secondary payer. The
5 commercial payer is the primary payer. After 33 months,
6 then Medicare becomes the primary payer.

7 MR. DeBUSK: [off microphone] So the answer is
8 what?

9 DR. MILLER: I'm sorry, I lost track of the second
10 half of the question.

11 MR. HACKBARTH: Would you repeat the question and
12 hit your mike.

13 MR. DeBUSK: The industry says access to care has
14 very little to do with Medicare economics. If it were not
15 for commercial payers who grossly subsidize the losses
16 incurred by treating Medicare beneficiaries, there would be
17 a major issue in access of Medicare beneficiaries.

18 I was just asking is this true?

19 DR. MILLER: What we do know is that, at least
20 when we look at use of services and access for Medicare
21 beneficiaries, we did not see that they are having access
22 problems. And to the extent -- I'm going to get there, I

1 know where you're going.

2 And to the extent that we're observing negative
3 margins here, we're acknowledging the payment issue and
4 making a recommendation to address it.

5 MR. DeBUSK: Let me take this out to the people
6 who pay the bills for all of this stuff, the manufacturer
7 out here in the industry today. The cost of a dialysis
8 patient to a company this unbelievable. It can actually
9 mean the difference in a profit or a losing situation on a
10 month to month basis.

11 It's our mission to pay the fair share, what's
12 right. And there's places, it's quite evident, that we
13 don't pay our fair share. You want to talk about jobs
14 leaving this country, where it gets down to, I work 2,500
15 people and you can believe I'm forced to take them out of
16 this country. But right there is one area that really,
17 really hurts industry a great deal.

18 You wonder is this good policy? Are we doing what
19 we need to do for this sector of our elderly patients? It's
20 questionable.

21 DR. REISCHAUER: Let me just reiterate something
22 that I've said a number of times before, which is I would

1 hope that we would do the capacity of the industry and the
2 access issue more in terms of stations than in terms of
3 centers because, as your information shows, the average size
4 of a center, in terms of stations, seems to be growing over
5 time. This seems to be driving a lot of the efficiencies,
6 economies of scale, that we're talking about.

7 I'd like to know -- and the differential margins
8 between the freestanding ones and the chain ones. If I go
9 to your numbers for 2003, I think you have a 3.7 percent
10 margin for the chains 2.4 overall, which means the balance
11 of the industry has a negative margin in 2003.

12 And so I think, in a sense, it's incumbent upon us
13 to ask where those are and are the chains spread out in
14 rural areas as well as in urban areas? I don't know the
15 answer to that, but I think we need to look at this in a lot
16 more fine-grained kind of way.

17 And I'm perfectly comfortable, unlike Pete, that
18 we're doing the right thing. We see overall negative
19 margins or compression here, and are making an appropriate
20 kind of response to that situation. But if it really is a
21 big chain versus the others story, we have to ask ourselves
22 about the others and are they the equivalent of critical

1 access hospitals or whatever, and the chains unwilling to go
2 into rural areas or certain areas?

3 I don't think that is the case but I'd like to
4 know.

5 MR. HACKBARTH: Any comment on that at this point?
6 Or is that something you can bring back for January?

7 MS. RAY: We'll look into the feasibility of
8 trying to put some maps together to look at the location of
9 facilities and their margin and their chain status, yes.

10 MR. HACKBARTH: Others?

11 MS. HANSEN: Can I ask a little bit more what was
12 in the report and not on the slides, relative to the home
13 dialysis or going further down over time?

14 But that there were some cost savings that tended
15 to occur, I think, with the home dialysis but that there
16 were other multiple reasons why people might prefer going to
17 the in-center.

18 Is there any thought about the difference? Are
19 there any qualitative differences in the quality of
20 complications or anything like that if somebody does
21 dialysis at home as compared to in-center?

22 MS. RAY: There is literature about that. I think

1 that's something that we would need to explore more fully in
2 the future. I think our section on home dialysis is a
3 starting point for us to look at this issue.

4 DR. MILLER: I think here what we're trying to
5 accomplish is to put a marker down that it was an issue that
6 we cared about that we were going to look into it and we
7 really haven't moved very far on it. But we wanted to just
8 sort of say this is the direction that we want to go in to
9 see if, in fact, anybody had any reaction or guidance to it
10 and so that the public knows that it's something that we are
11 going to pursue but not much to say about it right at the
12 moment.

13 MS. DePARLE: On that point of home dialysis, I'm
14 looking for my notes here. You have some data in here that
15 was very good about patient satisfaction with home dialysis,
16 the likelihood that a patient would use it and that kind of
17 thing. And then I think you talked about the reimbursement
18 difference being on the drugs and I guess raising the
19 question of is that part of the reason why more people don't
20 use home dialysis.

21 If we think we would like to encourage that as a
22 good alternative for patients it seems to me one of the

1 areas we need to look into is as something changed --
2 because you suggest that perhaps one reason why the other
3 drugs aren't reimbursed is because there are safety issues
4 with giving them in the home. Am I conflating two sections?
5 So should we look at that is what I'm trying to get to?

6 MS. RAY: Again, like Mark said, this is a marker
7 for an area that I think we want to explore more.

8 The point I raised in the paper is that the
9 profitability under pre-MMA payment policies may have
10 influenced providers' decisions to go in-center versus home
11 dialysis because there is evidence that suggests that home
12 dialysis patients use, on average, less drugs than in-center
13 patients.

14 Under post-MMA payment policies, where we've taken
15 much of the profit margin out of drugs, one question is
16 what's going to happen there?

17 The other issue is that Medicare right now pays
18 for erythropoietin when it's administered by a patient in
19 his or her home. It does not pay for other dialysis drugs.

20 MS. DePARLE: That was the issue I was looking at.

21 MS. RAY: One issue to explore here is the safety
22 of patients administering some of the other drugs that are

1 often used. I have heard from at least some providers that
2 there may be a question about the safety of patients
3 administering injectable iron, for example. But that
4 clearly is an issue that we need to explore.

5 MS. DePARLE: We do. And we also, in addition to
6 the safety, is it clinically less efficacious if some of
7 those drugs aren't available? And if so, no wonder
8 clinicians aren't recommending that people are doing at
9 home, if they also can't get reimbursed from Medicare.

10 So there's a whole bunch of issues there but I
11 hope we will -- I know you're interested in this. I hope
12 we'll spend some time exploring it.

13 DR. MILLER: I hate to ask things that I don't
14 know the answer to or even have a sense of, but my
15 recollection on the auditing, this is to go back and try and
16 give you a better answer than you got the last round from
17 me.

18 My sense on the ESRD is that they're actually
19 required by law to be audited. But they've done it more
20 than they've done it in some of the other areas. I think
21 some of the reason that we focus on it here is that we have
22 -- and this is what I'm really worried about saying -- some

1 greater degree of confidence when you compare an audited to
2 an unaudited report. Something has actually happened to it.

3 Whereas in the other sectors when you refer to
4 audited reports it's often not that they've really audited
5 the report. For example, in the hospital sector generally
6 there's not a lot of it that goes on. And when it goes on,
7 it's looking at the pass-through payments only and not the
8 rest of the cost report.

9 So I think some of our thinking here is we have a
10 little bit more of a leg to stand on here.

11 MS. DePARLE: I'm looking at Senator Durenberger,
12 maybe he can answer this. Why is it that by statute those
13 are required to be audited and others aren't? Does anyone
14 know?

15 MS. RAY: I forget. I think it was the BBA that
16 required it. And you know, my recollection is ProPAC made a
17 recommendation calling for the regular audit of margins,
18 again going back in history.

19 MS. DePARLE: So it goes back to audit factor.

20 DR. MILLER: Do you know what motivated if here,
21 as opposed to somewhere else? Was there some kind of IG
22 report?

1 MS. RAY: You mean what motivated the ProPAC
2 recommendation?

3 DR. MILLER: I just want you to know, she's
4 sniping at me from the sideline here.

5 MS. RAY: I'm sorry what motivated the ProPAC
6 recommendation? I don't know. I don't know what motivated
7 the inclusion of this provision in the BBA.

8 MR. HACKBARTH: Anybody else?

9 Okay. Thank you, Nancy
10 Next is inpatient rehab.

11 DR. KAPLAN: As Glenn said earlier, this is our
12 first payment adequacy assessment for inpatient
13 rehabilitation facilities, also known as IRFs.

14 The IRF PPS began on January 2002 and Medicare
15 spending for IRFs is \$6 billion in 2004.

16 I'm going to briefly review the factors for these
17 facilities that I presented in October, and then Craig and I
18 will present new information to inform your assessment of
19 adequacy and the update recommendation.

20 Factors from October include supply of IRFs,
21 volume of services and spending, and access to capital.
22 From 2003 to 2004 the number of IRFs entering the Medicare

1 program increased 1 percent. At the same time, volume of
2 cases increased 4 percent and spending increased 5 percent.
3 IRFs appear to have access to capital. 80 percent of these
4 facilities are hospital-based and have access to capital
5 through their parent institutions. As you heard this
6 morning, hospitals appear to have good access to capital.

7 Today the new information includes changes in
8 quality, new information on volume, changes in access, and
9 payments and costs.

10 To assess changes in quality of care for IRFs we
11 use a measure commonly tracked by the industry, the
12 difference between the discharge and admission scores for
13 the commonly used functional independence measure, known as
14 the FIM, which is incorporated in the assessment tool for
15 IRFs. The FIM measures physical and cognitive functioning
16 using 18 items that have a score ranging from one to seven
17 for each, with one the highest and seven the lowest.

18 In short, we are interested in whether there is no
19 change, with stable scores; an increase in the difference,
20 which would be improvement; or a decrease, which would be
21 deterioration. To compare quality at a national basis we
22 used the average difference in FIM at discharge versus

1 admission for Medicare patients in two ways, as shown on the
2 screen. These scores suggest that quality has remained
3 steady under the PPS.

4 To be paid as an inpatient rehabilitation
5 facility, IRFs must have 75 percent of patients admitted for
6 one or more of a list of conditions. CMS changed the
7 conditions considered appropriate for intensive
8 rehabilitation, as you can see from this graphic.

9 Polyarthritis was no longer included and the conditions you
10 see on the right were added. Polyarthritis was the
11 rationale for joint replacement patients which made up a
12 large share of IRF admissions, 27 percent in 2004.

13 CMS has said that the growth in joint replacement
14 patients treated in IRFs is what prompted their concern.

15 CMS's intention was to change the mix of patients
16 in IRFs by redirecting the least complicated cases to other
17 settings for rehabilitation, in addition to differentiating
18 between IRFs and other settings.

19 In 2005, when the threshold was 50 percent, the
20 volume of cases decreased an estimated 9 to 14 percent. The
21 9 percent decrease comes from the IRF industry. The 14
22 percent decrease is the result of our analysis of the first

1 half of 2005 compared to the similar period in 2004. Our
2 results are more conservative.

3 Not surprisingly, joint replacements have
4 decreased the most. However, there have been increases and
5 decreases in other cases, as well. A separate issue, which
6 we need to examine further, is the effect of CMS's guidance
7 to the fiscal intermediaries in program memoranda that
8 appears to be driving some of the decreases.

9 Access is hard to judge in any case. We know that
10 IRFs are not located everywhere. There are questions of
11 clinical appropriateness, who needs intensive rehabilitation
12 in an inpatient setting, especially in the context that
13 rehabilitation can be provided less expensively in other
14 settings.

15 We don't know what to tell you about access in
16 this area. On the one hand, before 2005 there were
17 increases in volume, IRFs, and Medicare spending. On the
18 other hand, there are the declines in volume in 2005.

19 MR. LISK: We will now move on to examine factors
20 that affect payments and costs, the last component of our
21 update framework. The above graphic shows how length of
22 stay has changed cumulatively since 1998 for IRFs. As you

1 can see, IRFs have experienced length of stay declines every
2 year for Medicare patients. The length of stay declines,
3 however, slowed somewhat after the implementation of the IRF
4 PPS.

5 What does this mean for cost growth? This chart
6 shows the cumulative change in payments and costs per case
7 since 1998. From 1991 to 2001, under TEFRA, we actually saw
8 in aggregate a reduction in payments per case and costs per
9 case. With the introduction of the prospective payment
10 systems for IRFs, however, we actually saw a huge increase
11 in payments per case of over 10 percent per year 2002 and
12 2003 as hospitals transitioned in to the IRF PPS over this
13 period.

14 Along with this rapid increase in payments came an
15 increase in costs per case of appeared to be lagged one
16 year, an increase of 2.4 percent in 2003 and 3.6 percent in
17 2004. Needless to say, this big jump up in payments led to
18 a rapid rise in Medicare margins for these facilities.

19 As you can see, the Medicare margin jumped up
20 substantially with the implementation of the IRF PPS, from
21 1.5 percent in 2001 to 11.1 percent in 2002, rising further
22 to 17.7 percent in 2003 when all IRFs were under the PPS.

1 In 2004 the Medicare margin was 16.3 percent.

2 I want to make you aware, though, that there are
3 some issues with HealthSouth's cost reports. HealthSouth is
4 the biggest provider of IRF services in the country. We
5 have attempted to adjust 2002 and 2003 for missing cost
6 information for these facilities.

7 In addition, there are some reporting issues that
8 likely result in an underestimate of Medicare allowable cost
9 for Health South in 2004. If HealthSouth data were excluded
10 from our analysis, the 2004 Medicare margin shown in the
11 overhead would be about 3 percentage points lower than what
12 is shown.

13 Before the PPS for IRFs, Medicare margins for
14 free-standing and hospital-based IRFs were similar, both
15 about 1.5 percent. After implementation of the IRF PPS,
16 however, while Medicare margins rose rapidly for both sets
17 of providers, the increase was much bigger for the
18 freestanding facilities. The differential was due mostly to
19 bigger increases in Medicare per case revenues for the
20 freestanding providers rather than differences in cost
21 growth. Overall essentially every group of hospitals we
22 examined by location, ownership, teaching status, et cetera,

1 had double-digit margins in 2004.

2 Overall, however, we see that 73 percent of IRFs
3 had positive Medicare margins in 2004. For-profit and free-
4 standing facilities had the highest margins. Rural IRFs,
5 government IRFs, and facilities with a low Medicare patient
6 share -- that is less than a 50 percent patient share -- had
7 the lowest margins. But almost all were still in double-
8 digit range.

9 There's wide variation in Medicare margins. A
10 quarter of all IRFs had a Medicare margin of 24 percent or
11 more.

12 So what do we expect will happen in 2006? We have
13 modeled 2006 payments and costs for IRFs using updates and
14 taking account of policy changes that affect payments in
15 2005 and 2006. These include updates of 3.1 percent and 3.4
16 percent in 2006, a change in the outlier threshold which
17 increased payments somewhat, and an adjustment for coding
18 improvements which resulted in a decrease in payments.

19 The biggest change we modeled, however, was the
20 implementation of the new 75 percent rule which Sally
21 discussed earlier. To model the 75 percent rule for 2006,
22 we assumed that at least 65 percent of IRF hospitals'

1 Medicare cases will be compliant, the standard required in
2 2007 in terms of the list of conditions that Sally presented
3 to you before.

4 As Sally has already discussed, we have seen a 9
5 to 14 percent decline in cases as hospitals try to become
6 compliant with the 50 percent standard in 2005. Projections
7 indicate a drop of as much as 29 percent in cases in order
8 for hospitals to become compliant with a 65 percent
9 threshold that will be in place in 2007.

10 To account for this drop in cases, we have made
11 assumptions about the reallocation of overhead and patient
12 care costs for these patients. In our model we've assumed
13 that discharges will fall by 29 percent and 75 percent of
14 overhead costs and 10 percent of patient care costs related
15 to these patients will be reallocated among the remaining
16 patients in the hospital.

17 Using these assumptions, we find that Medicare
18 margins will drop from 16 percent in 2004 down to about 8
19 percent in 2006.

20 If we have to change these assumptions to make
21 more or less conservative assumptions it would have the
22 effect of moving the 2006 margin up by as much as 4

1 percentage points or down by as much as 3 percentage points.

2 If Senate provisions that are in their
3 reconciliation bill pass and become law, it would hold the
4 compliance threshold at 50 percent in 2006 and 2007, and we
5 would anticipate that the Medicare margins would be in the
6 range of 4 to 7 percentage points higher than we have shown
7 here.

8 DR. KAPLAN: This is the first time we've
9 recommended an update for IRF. The draft recommendation is
10 the Congress should increase payment rates for the inpatient
11 rehabilitation facility prospective payment system by one-
12 half of the protected market basket for fiscal year 2007.

13 Up until recently IRFs had an increase in cases.
14 Volume is down now because of the 75 percent rule. We made
15 a conservative estimate and they still have healthy margins.

16 We're ready for your questions and comments.

17 DR. MILLER: Glenn asked me to just make a couple
18 of clarifications and then maybe make a point for the
19 Commissioners and the public that might be a natural
20 question.

21 Some of this is pretty complicated here. We have
22 a 75 percent rule cutting into or being implemented over the

1 next couple of years. That's going to have the impact of
2 potentially reducing discharges or admissions in these
3 facilities. So we made an assumption that, at this point in
4 the implementation of the rule, where they have to comply
5 with what -- the 75 percent rule at that point is you have
6 to be 65 percent. That means a third of the admissions, in
7 round numbers, we're assuming leave the facility and that
8 they don't replace them. That's a fairly aggressive
9 assumption. And then we made some assumptions about what
10 costs remain, and I want to make sure I get this right, but
11 we assume that the fixed costs, about 75 percent of them
12 stay and about 75 percent of the variable costs stay.

13 Now it might be a natural question, and this is
14 what Glenn was looking for me to clarify, for someone to say
15 tell me about the relative profitability of the people who
16 left versus the people who stayed. We're not able to
17 estimate that very directly because we can't estimate the
18 profitability of the given payment category, much like all
19 of the work that we had to go through on the inpatient site
20 to figure out the profitability of the DRG. So we can't
21 give a direct estimate of that.

22 But what Craig was saying there, when he was

1 talking about the pluses and minuses, what we did was more
2 and less aggressive assumptions about how much cost hangs
3 around after these discharges leave and that's what gets the
4 range. That's what we're trying to play with to see what
5 the potential margin would be.

6 This started off as a clarification and I get the
7 distinct sense that I lost everybody in the room. So with
8 my work done here, I'll turn off the microphone.

9 MR. HACKBARTH: It was a nice try.

10 Questions, comments?

11 DR. KANE: I'm trying to understand something
12 here. Is the 16 percent margin something that we feel needs
13 to be preserved? I don't really fully understand what's
14 going on. Or moved down to seven?

15 People looked at different industry segments and
16 for some a zero margin was okay, for some a 1 percent margin
17 was okay. Now we're looking at a segment where -- we're
18 recommending an update for one with a projected -- I'm just
19 confused as to what's our target?

20 DR. MILLER: A couple of things, unless someone
21 else wants to jump in. Since I did such a good job on the
22 last question, I've been asked to do this one as well.

1 In all seriousness, there's a couple of things
2 inside your question that are fair questions. First of all,
3 our we're doing here -- actually, is this meeting over?

4 MR. HACKBARTH: Go check the snow, Mark.

5 DR. MILLER: Should I leave? I think I need to
6 go.

7 There were several things that you said that
8 should be addressed. First of all, we're saying for the
9 last year here when we have data the margin was 16 percent.
10 But we know that this thing is going to happen, the 75
11 percent rule, which is going to have a dramatic impact on
12 admissions going to the facility and we're just estimating
13 as best we can, with a plus or minus kind of feel to it,
14 what we think the margin would be. That's one set of
15 sentences. That's what's going on on that slide, between 16
16 percent and 7.7 percent. So that's the first thing that's
17 going on.

18 The second thing that's going on is like every
19 other sector we put a bunch of information in front of you,
20 quality, access, supply, volume and the margin. And I think
21 it's really one of the reasons this commission exists, is
22 people sit around and say on the basis of that information

1 and their professional judgment -- expert judgment -- what
2 is the right thing to do in any given sector? I don't think
3 there's any standard that if the margin is equal to X then
4 you must do Y.

5 One other thing here, I think this recommendation,
6 which does have a little feel to it of we're not quite sure,
7 we're estimating what we think is going to happen here. I
8 think I would characterize the recommendation as being
9 somewhat driven by caution, that rather than zeroing it out,
10 since we're not 100 percent sure what's going to happen
11 here, I think we're taking a little bit more cautious
12 approach.

13 MR. MULLER: Could you also say that this 7
14 percent estimate is at the 65 percent threshold, and when we
15 go to 75 we'll probably knock it down a bit more.

16 DR. MILLER: Right, but that will be 2008 and
17 we'll be back here making another recommendation at that
18 point. But yet.

19 MR. MULLER: But going from the 60 to 65 to 75,
20 that will keep knocking it down. So one can either
21 anticipate that or not, depending on what your preference
22 is, but it's still going down a little bit more.

1 Are the HealthSouth numbers you're correcting
2 earlier, are they inside the 7 percent estimate?

3 MR. LISK: Yes, they are. And that's another
4 reason to say those margins are potentially overstated
5 somewhat. They do account for one-sixth of the revenue so
6 it's kind of hard to leave them out. They probably are
7 performing better than the other let's say freestanding for-
8 profit facilities because of just their size and their scope
9 but there are some issues. If you want to get into some of
10 the details about it I can share some of those with you.

11 But those numbers are in there, yes.

12 DR. REISCHAUER: Craig, did I hear you correctly
13 that you said 7.7 percent under our best set of very
14 uncertain estimates but if he really took the worst of all
15 the alternatives it's 4 percent?

16 MR. LISK: Yes. And then make adjustments for
17 HealthSouth and you might be down a little bit lower than
18 that. We have really what here is a wide range and we're
19 just giving you what we think is our best guess.

20 DR. REISCHAUER: But it's not minus 2.

21 MR. LISK: No.

22 DR. MILSTEIN: Following on Nancy's question and I

1 guess my prior point, since we're not even in the same range
2 as the margins that we've tolerated in other provider
3 sectors what would be the rationale in this particular case
4 for expecting a zero productivity update in this sector?
5 Here it's not even half, it's zero. It isn't like -- we
6 have plenty of margin for error, it sounds like, even
7 factoring in HealthSouth.

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

9 DR. MILSTEIN: That we haven't subtracted out from
10 our recommendation.

11 MR. HACKBARTH: We've taken more. The draft
12 recommendation -- and let me highlight again it's draft and
13 this is why it's draft, so we can get perspectives on it --
14 is for half of the projected market basket. The projected
15 market basket is 3.6.

16 So one way of looking at it is here we've taken a
17 1.8 percent reduction and expect them to handle that, as
18 opposed to other sectors where the general productivity
19 adjustment is 0.9. So this is actually a lower update, a
20 more aggressive update.

21 Whether it's still too high or unfair relative to
22 hospitals or dialysis facilities is still a legitimate

1 question. But it is larger than the normal productivity
2 deduction that we take.

3 MR. MULLER: I think the HealthSouth numbers can
4 really confound these estimates. Have they changed their
5 pricing as a result of some of the issues they've had?

6 MR. LISK: The issue with them is that due to the
7 accounting scandal they have not claimed fully depreciation
8 expenses because they're having to recalculate and estimated
9 the depreciation expenses that they have for their items.
10 And their home office expenses are being cautious with CMS
11 and what they claim is allowable home office expenses. So
12 they're not necessarily claiming fully what they, in the
13 long run, can claim for home office expenses. They're
14 dealing again with the aftermath of the accounting scandal.

15 From my understanding, essentially if an employee
16 is involved in dealing with anything with the accounting
17 scandal, they're not counting that time as an allowable
18 expense even though maybe 50 percent of their time or so
19 could be considered an allowable expense in other
20 circumstances. So that's why their costs are understated,
21 are likely understated. It's not a payment issue though.

22 MR. MULLER: But the higher margins are very much

1 driven by what they achieved in the past and they have had
2 to bring some of those down. Just like we had a company
3 with outlier issues a few years ago. Once you took that
4 out, it changed things, too.

5 MR. LISK: Right.

6 MR. DeBUSK: Before we start cutting this market
7 basket and getting into this too deep, this industry, as I
8 understand it, is redefining itself right now as to what
9 qualifies for rehab, et cetera, et cetera. So you're going
10 to have a whole shift of procedures, and maybe some new
11 ones, and certainly a lot being eliminated from the rehab
12 category for reimbursement.

13 The next two years a lot is going to shake out.
14 So what this thing is going to look like, I think is very
15 unpredictable. I think we ought to take a bit of caution
16 before we do too much.

17 MR. HACKBARTH: It is unpredictable and we can't
18 specifically address the relative profitability of the
19 patients leaving under the 75 percent rule. But in a
20 variety of ways the staff have tried to lay out conservative
21 assumptions that would help us take at least a plausible
22 guess at where that leads.

1 As Bob said, in the worst case we're talking about
2 4 percent after we go through this process, which compares
3 pretty favorably to a number of other sectors.

4 DR. CROSSON: I understand from the presentation
5 that we don't have data on the diagnosis-specific
6 profitability. It seems like from the discussion, or at
7 least the assumptions that one could make from where the
8 industry wants this to go or not go, that there's a
9 difference in the profitability between the diagnoses that
10 are now on the list of 13 and those that are not. Is there
11 some factual base for that or is that assumed from other
12 dynamics?

13 MR. LISK: The only thing we can say, we don't
14 know about the profitability. We do know that the cases
15 that are in a noncompliant category are in lower CMG-
16 weighted cases. The average weight of those cases being
17 considerably lower. It's like, I think, 0.96 or something
18 versus 1.34 for the complaint cases. There's a big
19 difference there. But we don't know, in terms of individual
20 profitability within those, what happens.

21 DR. CROSSON: Just one follow-up then. What you
22 know, did that go into the assumption of the 16 going to

1 7.7?

2 MR. LISK: Yes.

3 MR. SMITH: Very briefly, Glenn. Worst case, for
4 -- assuming making a HealthSouth adjustment to the 7.7, it
5 is a relatively comfortable margin coming on the heels of
6 several years of outrageously high margins.

7 I'm not quite sure why our bias in this case,
8 particularly for an industry which is so weirdly
9 distributed. This clearly is not a critical lynchpin of
10 health care providers across the United States. It is
11 concentrated in very specific places.

12 So I'm just not quite sure why our bias should be
13 toward the most conservative estimate in every case. When
14 we do that we get to a 4 percent margin after years of 17
15 percent margins, rather than being more aggressive on the
16 productivity side. We don't make a -- you suggested that
17 half a market basket was the equivalent of a big
18 productivity adjustment. It could simply have been a way of
19 compensating for bad pricing in the last few years.

20 MR. HACKBARTH: I think both points are well taken
21 and ideally I think we would tend to look at more than one
22 year and where they're coming from and where they're going

1 to and the fact that they're geographically not evenly
2 distributed. I think those are both good points.

3 DR. REISCHAUER: Some 82 or 83 percent of these
4 are hospital-based and I was wondering if we knew anything
5 about the PPS margins of the hospitals that have these
6 things? Are they a random sample of hospitals? Or are
7 these by and large the big healthy guys?

8 MR. LISK: I need to get back to you on that.

9 Many of them are teaching hospitals and some aren't.

10 DR. REISCHAUER: That's what I thought.

11 MR. LISK: We do know, in terms of the impact of
12 this rule, if we apply the impact of this on hospitals in
13 the aggregate it's about a 0.3 percent decline in overall
14 Medicare margin for the hospitals overall but not
15 specifically for the hospitals that have these things.
16 Which is about one in five hospitals have these things.

17 DR. REISCHAUER: When we look at other services
18 that are embedded in the hospital, hospital-based SNFs,
19 hospital home health, et cetera, outpatient, and we say oh
20 good Lord, look at these big negative margins. Well it's
21 because we can't really allocate the fixed costs correctly,
22 maybe.

1 I'm wondering if that's an argument that drives
2 down margins presumptively in other parts of our analysis,
3 what's going on here. Is there some different dynamic?

4 MR. LISK: I'm actually not sure about your
5 question.

6 DR. REISCHAUER: Take a hospital-based SNF. They
7 have very low margins; right? Hugely negative margins.

8 MR. LISK: Yes.

9 DR. REISCHAUER: And we say maybe those are real
10 or maybe the hospitals really don't allocate fixed costs
11 correctly. But it seems to be always a reason for why it's
12 so low. And I'm wondering well, maybe these are really 22
13 percent.

14 MR. LISK: Historically, under TEFRA, the IRF
15 margins for the hospital-based facilities were close to
16 zero. They did jump up with the advent of the PPS but not
17 as much as the freestanding facilities.

18 DR. KAPLAN: We also did an analysis where we
19 compared freestanding to hospital-based IRFs, exclusively
20 IRFs, and we found that past allocation really was not an
21 issue for this setting.

22 DR. KANE: To keep things going for one more

1 minute, on page eight this chart showing payment rates going
2 up, after you implement a change in payment system rates go
3 up -- it looks like 10 percent a year for a couple of years
4 if I'm reading this right.

5 MR. LISK: Yes.

6 DR. KANE: And your costs start to go up. I guess
7 you have to say what were you trying to accomplish with the
8 payment system? And then maybe we can talk about the
9 margins. Even the margins are almost the wrong focus.

10 This chart kind of makes me wonder what's going
11 on? What were we trying to accomplish?

12 DR. KAPLAN: I think I can explain why it went up
13 so much. In TEFRA obviously diagnosis made no difference.
14 You were paid the same rate no matter what your case mix
15 was. It was the facility specific limit.

16 When the PPS went in, they started paying on the
17 basis of comorbidities, which of course had not been a
18 consideration before. And that's part of the increase.
19 Also there was coding -- which you might attribute to coding
20 improvement.

21 So I think that that's a lot of why it went up, as
22 well as the length of stay went down a little bit after the

1 PPS was in.

2 DR. KANE: But doesn't this make you think there's
3 something you need to fix in payment system?

4 DR. KAPLAN: In the payment system? We actually
5 do feel that we need to look at the payment system but
6 that's not part of today's discussion. That's a lot of work
7 for the future, I think.

8 DR. KANE: But should that take -- again, because
9 this is my first time around, shouldn't that be taken into
10 account in thinking about payment adequacy when you see a
11 chart like that? Or are we just supposed to look at this
12 margin of 7 percent and all of the uncertainty around it and
13 think about it that way? Or maybe 4 percent.

14 MR. HACKBARTH: No. Good question.

15 MR. MULLER: There may still be higher or lower
16 margins on that but the average acuity of the patient should
17 go up quite a bit with going from 65 to 75. How it is after
18 the dust settles, who knows? But clearly by going to a much
19 higher acuity that should bring the rates down or the
20 margins down.

21 DR. KANE: Doesn't it often go the other way
22 around? Higher acuity brings higher margins? No?

1 DR. MILLER: Just so you don't feel like the Lone
2 Ranger or anything, this issue has come up and does come up
3 repeatedly in these conversations where you'll be looking at
4 payment adequacy and trying to struggle with an update
5 issue. People will ask regularly well, wait a minute, isn't
6 there distributional issue here? And then we'll try to
7 address that.

8 A really big obvious example that was the work
9 that we did on revising the payment system for the inpatient
10 hospitals that was driven by the specialty hospital, where
11 we're saying here's the update. But by the way there's a
12 whole bunch of underlying distributional issues here.

13 The only appeal I would make here is this is
14 literally the first time we've looked at this, too. Some of
15 the same reactions you're having, we're experiencing for the
16 first time ourselves as well. This is the first time we've
17 seen post-PPS information and had it to analyze here. So
18 these are all the right questions. It's just how fast we'll
19 be able to answer them will frustrate you, I'm sure.

20 MR. MULLER: I agree we're looking at this in a
21 way we haven't before, but this is a good argument for
22 having a good classification system in the whole post-acute

1 sector which we've discussed at length in other areas
2 because we have inconsistent was in the IRFs and the LTCHs
3 and the nursing home in terms of how to classify. So we
4 have spoken at length in the past about having a more
5 consistent way to classify. I think that would help these
6 discussions if we had that. Getting there is another
7 matter.

8 MR. HACKBARTH: Put up page eight, the graph that
9 Nancy was referring to.

10 As we move from the left in the TEFRA period to
11 the PPS period, how has the sector changed in terms of new
12 entrants? Has there been a significant increase in the
13 number of facilities or more for-profit? Or is it simply
14 much the same over the two periods?

15 DR. KAPLAN: I can only answer your question today
16 on the number of facilities. Basically the number of
17 facilities have increased about 2 percent per year in
18 general. So there hasn't been a huge amount of increase in
19 that.

20 There has been a bit of an increase in the number
21 of cases. So it seems that cases per facility have gone up.
22

1 We showed a 6 percent increase in case from 2002
2 to 2004. It was more rapid before PPS. It was 8 percent
3 before then. So even though there wasn't a great deal of
4 increase in facilities there was an increase in cases.

5 I don't have it broken down by type of facility.
6 I can do that and bring that back to you next month.

7 DR. NELSON: It's on page 11, if I understood the
8 question right. It in the handed out material. Page 11 has
9 got the growth broken down by freestanding, proprietary and
10 so forth.

11 DR. KAPLAN: Off facilities yes, but not
12 necessarily by cases.

13 MR. LISK: In terms of changes in Medicare
14 discharges on a per facility basis, it was growing actually
15 fairly rapidly, in 2001 5.3 percent, 2002 4.2 percent, 2003
16 3.9 percent, and in 2003 to 2004 2 percent.

17 DR. KAPLAN: So more rapidly pre-PPS than post-
18 PPS.

19 MR. HACKBARTH: Any others?

20 DR. WOLTER: It's on another point and I'm
21 certainly no expert in the area of rehab. But as a
22 clinician the changes in the arthritis criteria certainly

1 are not intuitive to me as ones that necessarily make sense.

2 And also, whether it's 50 percent or 60 or 75
3 percent that isn't intuitive to me as the best way to manage
4 how admitting is done and not done either.

5 In the long gone, just to emphasize Ralph's point,
6 I think a better patient classification system that allows
7 us to focus on what a patient needs would serve this system
8 a lot better than those kind of arbitrary clinical criteria.

9 MR. HACKBARTH: In our comment letters to CMS
10 we've expressed reservations about the 75 percent rule and,
11 in particular, how it was developed and implemented. So
12 there is, I think, a lot of reason to doubt that it's the
13 perfect way to approach this.

14 On the other hand, the problem that we tend to
15 face in the post-acute area, as we have these new types of
16 payment systems going into place that creates significant
17 potential for people to gain. And often the new settings
18 are higher cost than other settings where people with the
19 same problems get treated in other communities that don't
20 have the specialized post-acute facilities.

21 And as in the case of, for example long-term care
22 hospitals, what we're trying to do in general is make sure

1 if we're going to pay for expensive settings that it's the
2 right people, the people who really need it. The 75 percent
3 rule I think is maybe an especially crude effort to
4 accomplish that but I think that's the basic objective.

5 And I'm sympathetic with that. I wish we could do
6 a better. A think ideally, as Ralph was saying, where we
7 want to get in the long run is that we have common
8 assessment instruments that allow us to assess where people
9 ought to be and assess across settings performance.

10 DR. WOLTER: I do understand the short-term
11 drivers. I think the point really is longer-term this isn't
12 probably the place it will end.

13 MR. HACKBARTH: Any others?

14 Okay, thank you very much.

15 Long-term care hospitals.

16 DR. KAPLAN: This is also our first payment
17 adequacy assessment for long-term care hospitals.

18 The long-term care hospital PPS began fiscal year
19 2003 and Medicare spending for these facilities in 2004 was
20 \$3.3 billion.

21 I'm going to do the same thing that I did with the
22 IRFs. Today we're going to briefly review the factors I

1 presented in October and then Craig and I will present new
2 information.

3 So for the factors I presented in October we found
4 that the number of long-term care hospitals has been
5 increasing since 1990 and the rate of increase accelerated
6 under PPS. The number of long-term care hospitals increased
7 12 percent from 2003 to 2004. The volume of cases increased
8 21 percent during the same period. And Medicare spending
9 increased almost 38 percent during that one year.

10 Beneficiaries access increased from 2001 to 2004
11 as the supply of long-term care hospitals, beds and
12 beneficiaries' use increased. Long-term care hospitals
13 appear to have access to capital, evidenced by for-profit
14 firms being able to borrow, to repurchase their own stock,
15 and by both for-profit and nonprofit long-term care
16 hospitals entering the program.

17 Now we turn to new factors: changes in quality
18 and payments and costs.

19 We find mixed results for three different types of
20 measures for quality for long-term care hospitals. We found
21 a small improvement in the shares of patients who died in
22 the long-term care hospital and those readmitted to the

1 acute care hospital. However, these indicators are not risk
2 adjusted.

3 We also investigated whether the AHRQ patient
4 safety indicators developed for the acute care hospitals
5 could be used for the long-term care hospitals. To
6 calculate these PSIs, we eliminated any patients that had a
7 PSI diagnosis in the acute care hospital. We then risk
8 adjusted the results.

9 Four PSIs had results that appeared to be stable
10 based on the number of patients and face validity:
11 decubitis ulcer, infection due to medical care,
12 postoperative pulmonary embolism or deep vein thrombosis,
13 and postoperative sepsis. All four of the indicators from
14 2003 to 2004 increased.

15 However, caution is needed in interpreting these
16 PSIs. AHRQ did not develop them for long-term care
17 hospitals and changes in coding also could affect the
18 results.

19 There is a need for better measures of quality for
20 long-term care hospitals. In June 2004 we recommended that
21 long-term care hospitals be defined by patient and facility
22 criteria. Those criteria would include a standard

1 assessment instrument that might incorporate data to measure
2 outcomes.

3 One long-term care hospital association and a
4 large chain have independently developed quality indicators
5 and some of these indicators are extremely similar but the
6 measures are very different. We're encouraged that the
7 industry is starting in this direction but greater
8 validation of the measures is needed. Decisions on a data
9 collection strategy also would have to be made. In
10 addition, CMS needs to be involved in this work.

11 MR. LISK: Now we'll move on to examine factors
12 that affect payments and costs per case, the last component
13 of our update framework, and I'll present you similar stuff
14 as you saw for IRFs.

15 The above graph shows how length of stay has
16 changed since 1998. As you can see there was essentially no
17 change in average length of stay from '98 through 2001. But
18 in 2002 and 2003 we see fairly sizable declines of 4 percent
19 and 4.5 percent. In 2004, however, we saw a slight uptick
20 in length of stay.

21 What does this mean for payments and costs?

22 This next chart on your screen shows a cumulative

1 change in payments and costs from 1998 through 2004. As you
2 can see during TEFRA, the left part of the graph, payments
3 and costs grew together. But after implementation of the
4 long-term care hospital PPS, the right part the graph, we
5 saw a rapid growth in payments in both 2003 and 2004 of 5.5
6 percent and 13.2 percent respectively.

7 If we look across, however, the first year of the
8 PPS brought essentially no change in costs per case. In
9 2004 costs per case climbed almost 9 percent, possibly in
10 response to the large increases in payments they received
11 after the implementation of the prospective payment system.

12 So what does this all mean for the margin?

13 As you can see in this overhead, margins for long-
14 term care hospitals were near or just below zero in the
15 aggregate under TEFRA. Under the long-term care hospital
16 PPS Medicare margins have increased rapidly, to more than 5
17 percent in 2003 and 9 percent in 2004.

18 Examining the distribution of margins for 2004 we
19 find that 23 percent of long-term hospitals had negative
20 margins. We find that in 2004 for-profit facilities and
21 hospitals within hospitals had the highest margins and
22 government hospitals had the lowest.

1 Finally, we see a rather wide distribution in
2 performance under Medicare, with more than a quarter of all
3 hospitals having Medicare margins exceeding 17 percent.

4 DR. KAPLAN: Before we talk about modeling the
5 2006 margins, I want to remind you about the 25 percent rule
6 for hospitals within hospitals. We've discussed the 25/75
7 and that type of thing,
8 there

9 When the policy phases in hospitals within
10 hospitals will be limited in the share of cases they can
11 admit from their host hospitals. The phase-in begins this
12 fiscal year.

13 Hospitals within hospitals have higher margins
14 than freestanding long-term care hospitals in 2004. Despite
15 our desire to model the effect of the 25 percent rule when
16 modeling 2006 margins, we are unable to do that at this
17 time.

18 For purposes of projecting the 2006 margins we
19 modeled the changes on the screen. In 2005 long-term care
20 hospitals received a market basket increase adjusted for
21 budget neutrality for an update of 2.6 percent.

22 In 2006 several changes affected long-term care

1 hospitals' payments. First there was a market basket
2 increase of 3.4 percent. At the same time, the outlier
3 threshold decreased and payments increased. Finally, when
4 the inpatient PPS changed the case mix groups, LTC-DRGs --
5 the case mix groups -- also changed and the relative weights
6 changed, resulting in a decrease in payments. When we
7 modeled the estimated 2006 margin, the result was 7.8
8 percent.

9 Our findings suggest that long-term care hospitals
10 are more than adequate based on an increase in
11 beneficiaries' access to long-term care hospital care, a
12 very rapid increase in supply of long-term care hospitals,
13 and even faster increase in volume of services and spending.

14 A mixed picture on quality but one that does not
15 suggest anything about the level of payment, that LTCHs
16 appear to have adequate access to capital and a Medicare
17 margin of almost 8 percent.

18 This is the first time we're recommending an
19 update for long-term care hospitals. The draft
20 recommendation is that Congress should eliminate the update
21 to payment rates for long-term care hospital services for
22 rate year 2007.

1 We welcome your questions and comments.

2 MR. HACKBARTH: Go ahead, Nancy.

3 DR. KANE: I'm not even going to say it because I
4 know you know.

5 DR. REISCHAUER: 7.7 is different from eight.

6 DR. KANE: You know what I'm thinking.

7 MR. HACKBARTH: Actually, I think there's a
8 Journal article in the making here on when PPS works and
9 when it doesn't.

10 This was an era where we decided prospective
11 payment worked for hospitals, created incentives that helped
12 reduce length of stay. So we've got a hammer. Everything
13 is a nail. We're just going to start whacking everything,
14 even if we don't have the prerequisites like a good case mix
15 tool or definitions of who needs services, we're just going
16 to create a PPS. It doesn't always lead to better results
17 than cost reimbursement with limits, at least from a
18 financial standpoint.

19 DR. REISCHAUER: I look at these numbers and they
20 infuse humility in your analytical abilities because LTCH
21 were churning along in the late 1990s and early 2000s with
22 negative margins, slightly negative margins on Medicare. 73

1 percent of their business is Medicare, so they're largely a
2 Medicare kind of outfit. The number of them growing rapidly
3 and the number of for-profit ones are growing rapidly. And
4 they're freestanding too, so it can't be some kind of
5 hospital kind of shifting of costs.

6 You wonder what's wrong with all the economics
7 training I got, that suggested that markets where people are
8 losing money, the number of institutions should begin to
9 contract. How do we explain this?

10 DR. KAPLAN: Go ahead.

11 MR. LISK: Some of it is under TEFRA how you come
12 under the system. And it may be in anticipation that they
13 were going to be going under a PPS in the future, at some
14 time in the future. So under TEFRA, when you first come in,
15 you're paid on cost for the first -- was it two years, I
16 believe -- to establish your TEFRA limit.

17 DR. REISCHAUER: But they had negative margins.

18 MR. LISK: The other thing that happened too, is
19 in BBA --

20 DR. REISCHAUER: So the prospect of losing money
21 forever is what attracts them?

22 MR. LISK: Also, the BBA, I believe, put in some

1 limits that put a cap on the TEFRA rate at the 75th
2 percentile.

3 DR. KAPLAN: The BBA made a big difference.

4 MR. LISK: So it did have an impact on lowering
5 some of the hospitals' margins. There's distribution there
6 that is underlying this, too.

7 DR. KAPLAN: This is an aggregate margin.

8 DR. SCANLON: The issue is you can't just take
9 economics courses. You have to take accounting courses,
10 too.

11 [Laughter.]

12 DR. SCANLON: We've seen this with other PPSs as
13 they've gone into place. That all the costs don't turn out
14 to be costs because when you're operating under a cost-based
15 system you may have related party transactions which have a
16 profit in one of your cost items, you may have sort of
17 capital expenses which turn out to be much higher on the
18 accounting side than they are on the real side. And so it
19 turns out to be very profitable to operate at a negative
20 margin.

21 MR. DeBUSK: [off microphone.] Those are not real
22 dollars on the other side.

1 DR. SCANLON: Not necessarily.

2 DR. REISCHAUER: John is going to say we have to
3 be an actuary, too.

4 MR. BERTKO: No. The actuary in me is looking
5 back to your slide two and the 21 percent number there.
6 Which if I'm reading that correct, is that a one year
7 increase in the number of cases?

8 Alan and I were just looking at this is a very
9 large number. So one can only say that it is pulling cases
10 out of some other facility. Do we have an idea which wants
11 and why they're being pulled out, other than the money?

12 DR. KAPLAN: No, we don't know that at this point
13 as to where they're coming from. We did an analysis that we
14 reported in June 2004 and we really didn't look at where
15 they had been taking patients from.

16 MR. MULLER: You could be in a hospital-based SNF
17 at minus 17 percent or you can an LTCH at plus 20.

18 MR. HACKBARTH: Didn't you show us a map last
19 time, or actually a series of maps, that says here's the
20 number and in such-and-such a year, and it just sort of
21 grew?

22 DR. KAPLAN: I'll be happy to bring that series of

1 maps back in January.

2 MR. HACKBARTH: Part of it is the proliferation of
3 LTCHs and geographic spread. It's still limited but it's
4 spread to new geographic areas. But they were cared for in
5 SNFs.

6 DR. MILLER: To the two points, it's important to
7 remember that this was relatively a small base. For
8 Medicare terms relatively small base, probably any other
9 room it would be a large one. So we're talking about
10 increases in facilities in cases off of a small base and
11 growing pretty rapidly.

12 And then to the point of where they're coming
13 from, and I'm going to not speculate here but just
14 extrapolate a little bit. When we did the long-term care
15 report a year or a year-and-a-half ago, we found once you
16 controlled for various things that the substitutes in the
17 markets where these existed were that SNF and the hospital.

18 So to the extent that we have notionally an
19 answer, that's where we think these are coming from. I
20 wouldn't necessarily say this is it, but that is notionally
21 what we were finding about a year ago or so.

22 MR. BERTKO: So the question I would have is if

1 they come out of the hospital, as Alan and I were just
2 talking in a sidebar, that that is probably a cost
3 reduction. If they come out of a SNF you might get a
4 quality increase but you also get a cost increase maybe?
5 I'm curious.

6 MR. HACKBARTH: It depends on the exact
7 circumstances if they come out of the hospital. They were
8 in the hospital, we're paying a fixed amount per case. If,
9 in fact, they are outliers --

10 DR. KAPLAN: What we found was that -- I can't
11 remember what we found on the outliers. I only remember
12 hospitals within hospitals versus freestanding.

13 Basically what we found is that if long-term care
14 hospitals were allowed to admit every type of patient then
15 it costs Medicare money. This was pre-PPS.

16 But if they admitted people who the sickest and
17 who appeared to need this type of care the most, then it was
18 more money but it was not statistically significant. That's
19 basically what we found. But we haven't done it since the
20 PPS.

21 MR. HACKBARTH: That was the foundation for our
22 recommendation that we need patient and institutional

1 criteria to define who should be eligible for this care.

2 Other questions or comments on LTCHs?

3 DR. REISCHAUER: Haven't hospital-based SNFs been
4 closing?

5 DR. KAPLAN: Yes.

6 DR. REISCHAUER: I was just wondering whether --

7 DR. KAPLAN: About a third of them have closed.

8 DR. REISCHAUER: 27 of the 38 LTCHs that came into
9 existence in 2003 to 2004 were hospital-based. I wonder if
10 hospital-based SNFs are being converted into LTCHs because
11 of a more favorable payment standard?

12 MR. MILLER: [off microphone] Jennie, this is one
13 of yours.

14 [Laughter.]

15 MR. HACKBARTH: Any others?

16 Thank you very much.

17 Next is skilled nursing facilities.

18 MS. LINEHAN: She's not sitting up here, but I
19 want to first acknowledge Carol Carter's work on some of the
20 quality section in this chapter, and I might be turning
21 around to ask her a question.

22 In our March report, we'll be making an update

1 recommendation for skilled nursing facilities for 2007.

2 CBO estimates that Medicare spending on SNF
3 services will be \$17.8 billion in 2007. The average annual
4 growth in spending is expected to be 3.5 percent between
5 2004 and 2015.

6 Last time I talked about supply, volume, access
7 and quality in this sector. This time I'm going to discuss
8 access to capital and payments and costs before I review
9 briefly the factors that I presented in October. And then
10 I'm going to discuss some of our recommendations for
11 improving quality measurement in this area.

12 Access to capital for SNF varies by the type of
13 control of the nursing home, whether the facility is part of
14 a larger organization. I should also note that when we
15 discuss access to capital for SNFs, we're actually talking
16 about the nursing facility, because most SNF care is
17 delivered in a nursing facility that also provides long term
18 care.

19 Large publicly traded companies that offer skilled
20 nursing facilities saw their stock values increase over the
21 past year and several chains reported facility construction
22 and renovation. An analyst we spoke to about this sector

1 said that investors see untapped value in nursing facilities
2 and have purchased or expressed interest in purchasing
3 nursing homes. And also said that CMS's RUG refinements
4 announced this year removed an element of considerable
5 uncertainty from the payment environment for SNFs.

6 Large chains regard Medicare payments favorably
7 and continue to seek to increase the Medicare share of
8 patients to improve their overall financial performance.

9 The not-for-profit SNFs appear to face more
10 limited access to capital, although data on the demand for
11 access to capital is generally less available for not-for-
12 profits. Analysts continue to have a negative outlook for
13 the non-profit SNF sector. Annual public debt issuance for
14 non-profits dropped again in 2004 to \$368 million, and it's
15 expected there won't be many investment grade nursing homes.

16 Nursing homes may access capital through mortgages
17 and other loans relatively cheaply, as interest rates remain
18 low, but we don't know the extent to which this type of
19 borrowing is happening.

20 It's also worth noting that to the extent that we
21 assess access to capital to determine what the Medicare
22 payment update should be, it's worth noting that there are

1 other government programs that exist to insure mortgages for
2 nursing facilities and assisted living facilities. Through
3 HUD facilities can obtain insured mortgages for construction
4 and renovation of facilities. In fiscal year 2004, HUD
5 insured mortgages totaling \$1.5 billion for nursing
6 facilities and assisted living facilities, but most of that
7 is for nursing facilities.

8 Now moving on to our margin discussion. In fiscal
9 year 2004 Medicare margins for all freestanding SNFs, which
10 are about 90 percent of SNFs or 13.5 percent, the margin for
11 hospital-based SNFs continues to be drastically negative.
12 It was negative 85.8 in 2004.

13 We see some variation by facility type but even
14 among freestanding facilities we see variation. Margin for
15 rural facilities continued to be higher than those for urban
16 facilities. This difference has persisted since the
17 beginning of the PPS.

18 Based on 2004 cost report data we estimate that
19 the 2006 aggregate Medicare margins for SNFs is 9.7 percent.
20 This reduction from the base year is a function of a
21 combination of payment changes that will be effective in
22 2006 including a full market basket, RUG refinements and the

1 elimination of the add-ons. The combined effect of these
2 changes is estimated to be a 0.1 percent increase across the
3 industry and a negative 0.4 percent increase for
4 freestanding SNFs. Hospital-based SNFs are actually
5 expected to see bigger payment increases due to these
6 changes.

7 As I said, we find differences in margins between
8 facilities based on facility characteristics, and I'm going
9 to talk about one of those differences which is the
10 difference between the margins of proprietary and voluntary
11 facilities.

12 Although the estimated overall SNF sector margin
13 is adequate to cover the costs of providing care to Medicare
14 patients these differences in margin by facility type mean
15 that as the margins are projected to decline in 2006 certain
16 categories of providers -- government facilities and
17 voluntary facilities -- margins are approaching zero.

18 We looked at differences between proprietary and
19 voluntary facilities for evidence of what may be driving the
20 differences in these margins and I wish I had something
21 conclusive to tell you. But we did find that in 2004
22 voluntary facilities had an aggregate higher cost per day

1 than proprietary facilities. And then we looked at the cost
2 growth differences between 2000 and 2004. Costs per day
3 started out higher in voluntary facilities, grew at a higher
4 rate, so the differences have persisted over time.

5 We also found differences in the average MDS short
6 stay quality measures by ownership type, but these measures
7 aren't risk adjusted so differences could be reflecting the
8 severity of patients. In the absence of good quality
9 measures for SNFs we can't determine whether cost
10 differences were actually related to quality differences.

11 We didn't find evidence of difference in case mix,
12 as measured by the share of days in the RUG categories.
13 However, facilities could vary on patient characteristics
14 that may affect cost, such as the use of costly prescription
15 medications, but aren't captured by the RUGs.

16 And finally, facilities may have different cost
17 structures. For example, voluntary facilities may have
18 higher nursing or overhead costs.

19 Regardless of whether the differences in the
20 margin by type of facility characteristic characteristics
21 reflect differences in efficiency, patient characteristics
22 or both, we do know that the payment system does not target

1 payments based on patient resource needs and that RUG
2 refinements did not address the problems with the payment
3 system, and that the payment system is currently based on
4 outdated case-mix weights.

5 We plan to investigate alternative ways to improve
6 the payment system to pay all providers for the provision of
7 SNF care. And we also see from this that case mix adjusted
8 quality measures are critical to ascertaining what we're
9 getting in facilities with divergent costs.

10 Now I'll quickly review what was in the chapter
11 and what I presented in October.

12 The overall supply providers remained stable in
13 2006 with the share of freestanding SNFs continuing to grow
14 and the share of hospital-based SNFs continuing to decline.
15 Volume is measured by total days, total payments. And total
16 stays increased in 2003, the latest year for which we have
17 data.

18 And increased use, even with the loss of some
19 payment add-ons, suggests continued access for Medicare
20 beneficiaries.

21 We continue to have limited measures of SNF
22 quality. Two of the MDS-derived measures we have show no

1 change in quality and one shows some improvement.

2 As I just mentioned a minute ago, access to
3 capital appears good for for-profits, less information on
4 not-for-profits, and the margin in 2004 is 13.5 percent and
5 is expected to decline in 2006.

6 So, as we've been doing in all other sectors to
7 start our discussion, last year we recommended no update for
8 SNFs and that's the recommendation you see on the screen.

9 SNFs received a full market basket update in 2006
10 but that, combined with other payment changes, resulted in a
11 net update of, as I said, before 0.1 percent. Current law
12 calls for a full market basket update in 2007 and that's
13 estimated to be 3.4 percent.

14 Now I'll review the Commission's long-standing
15 concerns about the distribution of SNF payments. We think
16 this is an important discussion to have in this context
17 because although the overall payment levels appear adequate,
18 payments are likely not targeted to patients' resource uses.

19 The payment system was refined but CMS has
20 acknowledged in their final rule that work in continuing to
21 refine the payment system is still needed.

22 We've had basically three criticisms of the

1 payment system since its inception. It's related to the
2 payment for non-therapy ancillary costs, the payment for
3 rehabilitation services based on the actual or estimated
4 amount of therapy provided rather than some kind of
5 predictor of the need for therapy, and the payment rates are
6 based on relative weights that are old and are expensive and
7 time consuming to update.

8 This leads us to our second recommendation which
9 is to adopt a new classification system for care in the
10 skilled nursing facilities.

11 The implications of this would be no spending
12 implications but would lead to better accuracy and improved
13 equity among providers.

14 Finally I'm going to move on to discuss some of
15 what we discussed in the draft chapter about the need to
16 improve quality in this sector, quality measurement.

17 In light of the limited set of currently used SNF
18 quality measures, we continue to investigate avenues for
19 measuring SNF quality and ways to improve the data to assess
20 SNF quality. Recall that the three MDS-based measures that
21 are currently the only publicly reported SNF quality
22 measures are limited for several reasons. They're not

1 collected at admission and discharge. One of the measures,
2 pressure ulcers, was not found to be valid in repeated
3 studies, and they don't capture the most important dimension
4 of SNF care or tell whether patients has benefitted from
5 their care.

6 CMS has tested and validated additional short stay
7 measures but these sort of suffer from the same problems.
8 We don't have measures for patients who don't have a 14-day
9 assessment, which is about half of the SNF patients.

10 CMS has added one process measure of flu and
11 pneumonia immunization rates in nursing facilities, but we
12 still have a fairly limited set. So last year we recommend
13 additional ways to improve quality measurement for SNFs,
14 including assessing functional status at admission and
15 discharge from the SNF for all patients.

16 We also discussed additional measures,
17 rehospitalization and discharge to the community, that have
18 been developed by researchers to assess important dimensions
19 of SNF care. These measures could be calculated from
20 existing data but are not currently part of any publicly
21 available data produced by CMS.

22 Because of the limited set of SNF measures, we

1 continued this year to review literature and interview
2 experts about additional avenues for developing SNF-specific
3 quality measures. As in another settings, we found that
4 process measures could be used to assess quality in the SNF
5 setting. Outcome measures are the gold standard quality
6 measures but process measures can complement outcomes
7 because they help providers identify steps to improve care.
8 Process measures also assess care that is completely under
9 the control of the provider.

10 We reviewed literature on guidelines applicable to
11 aspects of SNF care and experts told us that process
12 measures were viable in the SNF setting because there are
13 important care processes that should be followed in the SNF.
14 These guidelines could potentially be adapted as process
15 measures of quality. Some of these guidelines, such as
16 pressure ulcer prevention and pain management, apply broadly
17 to all SNF patients. Others, such as glucose monitoring for
18 diabetic patients, are relative to patients with specific
19 diagnoses.

20 Additional work to assess the strength of the
21 clinical evidence around and the level of consensus for
22 process measures is needed. An additional challenge to

1 developing process measures is related to data collection.
2 Claims data and the MDS with modifications could be used to
3 develop some measures but others would likely require new
4 data collection efforts, for example to know whether a
5 patient has received particular medications. In addition,
6 diagnosis coding would need to be improved to determine
7 diagnosis specific measures.

8 We're reiterating our recommendation last year and
9 adding that we think that process measures should be
10 included in any SNF-related quality measures that are
11 developed.

12 That concludes my presentation. I'll take your
13 questions.

14 MR. HACKBARTH: Questions?

15 MS. HANSEN: Just going back, first of all, to the
16 profitability of the voluntary and government nursing homes
17 vis-a-vis the for-profit sector, is there a description of
18 the relative percentage of some of those facilities also
19 serving Medicaid populations, as well? I know this is
20 Medicare only, but whether or not that has impact at all in
21 terms of spreading some of the expenses due to the Medicaid
22 reimbursement.

1 MS. LINEHAN: I can't directly address the
2 Medicaid question but we did look at differences in Medicare
3 share. It was share of days. We didn't find big
4 differences in aggregate in the voluntary and proprietary
5 facilities. I think it was 10 percent for the voluntary and
6 13 percent for proprietary. That was a surprise to me.

7 I can't directly address the Medicaid question but
8 that's definitely something that could also be related to
9 this that I didn't mention.

10 MS. HANSEN: Part of just hits me because I'm so
11 accustomed to Medicaid facilities. And oftentimes the
12 voluntary and the governmental sector end up having a higher
13 proportion of that. Given the kind of reimbursement that
14 occurs, it's the cost reporting as to what gets reported on
15 the Medicare side as to how they spread that.

16 But I just wonder whether that potentially colors
17 the kind of reporting that comes out of this when other
18 hospitals can kind of pretty well be more exclusive to a
19 Medicare population only. That's the source of that.

20 The other thing, this is my first year also but I
21 really do concur with your third recommendation, even though
22 this is a reupping again, to make that recommendation on

1 quality measures. That seems to be absolutely crucial in
2 terms of now maybe with the new RUGs, whether that helps at
3 all.

4 But the kind of measures to measure quality in a
5 Medicare stay just really needs to be examined. I think
6 it's put forth here. But however we can continue to put
7 some muscle behind that, I really would support.

8 DR. SCANLON: I think this is a great summary of
9 the issues with respect to SNFs.

10 I have one comment about draft recommendation two,
11 and it's the third bullet about a new system based on data
12 that are easier and less expensive to update.

13 CMS did have a contract in terms of the revision
14 of the RUG system and that was actually, I think, one of the
15 questions that was being considered. I think that while
16 this would be potentially a wonderful ideal to have, it's
17 not clear that there's a ready solution that's going to do
18 this. I think that it's perhaps more important to say bite
19 the bullet and collect the data to update the system and
20 make that recommendation. And maybe in the text say think
21 about how you can do this on an ongoing basis.

22 But to let a system that's almost been in place --

1 or soon it's going to be in place 10 years -- to have it
2 based on data that become so old, and we recognized from day
3 one about how thin they were in terms of different types of
4 residents. It just becomes unconscionable, given the amount
5 of money were spending here.

6 So I think we've got to make the investment, we
7 should be making the investment, to have the right data,
8 even though we know it's expensive to do.

9 MR. HACKBARTH: Would you propose, Bill, to drop
10 the last bullet from the recommendation and put it in the
11 text?

12 DR. SCANLON: I would propose that it be based on
13 more current data or make part of the recommendation to make
14 the investment to collect the data to update the system.

15 MS. LINEHAN: CMS is actually redoing a time
16 study. It's in the works and they're planning on doing it
17 next year.

18 You're right. I mean, this is more of an ideal.
19 I think what we're thinking for the future is this would be
20 one of the dimensions that we would use to evaluate
21 alternatives.

22 DR. SCANLON: Okay.

1 DR. MILLER: I want to pick up because I see your
2 point. But I also want to make sure that the significance
3 of what we're talking about with recommendation two isn't
4 missed. Of course, I want to be sure I'm right here.

5 The comment you're referring to refers to the
6 information that would be used to support RUGS; is that
7 right? That's fair and we can change it and we can discuss
8 it in the text. So no problem there.

9 I just want to be sure all the commissioners and
10 everyone else understands what when we talk about this we're
11 saying it could be something different than RUGS, too, when
12 we say adopt a new classification system. It could be RUGS.
13 It could be something altogether different or some more
14 significant modification of RUGS.

15 But that doesn't change your comment. I just want
16 to make sure that everybody understood the depth of what we
17 were talking about here.

18 DR. SCANLON: I do think that the CMS contract
19 did, in some respects, have an open mandate to consider
20 alternatives. But we were kind of back in the current mode,
21 because it's not clear that there is something that's right
22 out there that you can pick up on.

1 MR. MULLER: With the big difference between the -
2 - I think the total margins is 13 and the hospital-based --
3 I think you said something like minus 80. But it's minus
4 20. It's a big difference. And especially in light of the
5 conversation a few minutes ago about the LTCHs and so forth.

6 Do we have any policy vehicle for looking at
7 updates on or payment on the hospital-based different than
8 the total? Because obviously when we have something at
9 minus 20, minus 30, minus 80, that's something we should be
10 looking at in terms of adequacy. If it has policy
11 consequences that -- we were speculating loosely earlier
12 that some of this may be some of the reason for the LTCH
13 growth. But that would have been unreasonable assumption,
14 given the kind of differences in the margin.

15 So do we have any policy vehicles to address that?

16 MS. LINEHAN: What I was going to say is you did
17 recommend a differential update at one point.

18 MR. HACKBARTH: I think that was three years ago.

19 MS. LINEHAN: I don't know if that's what you're
20 talking about, but you did it before.

21 DR, REISCHAUER: I think the first question you
22 want to answer is is there a reason to keep these alive if

1 under an efficient payment mechanism they can't hack it? We
2 did go through analyses that seemed to show that their
3 patients weren't a whole lot different in the areas where
4 hospital-based SNFs existed other facilities of one kind or
5 another were capable of handling these patients.

6 So I think we'd have to justify the need for this
7 as a particular setting for that institution before we could
8 justify an additional payment.

9 MR. MULLER: But you also have to look at it
10 within the spectrum of care. So if you're paying more in an
11 LTCH than in a hospital-based SNF, you would want to make
12 that kind of opportunity argument, wouldn't you?

13 DR. REISCHAUER: Now you're admitting guilt on the
14 last session.

15 MR. MULLER: I'm not admitting guilt.

16 [Laughter.]

17 DR. WOLTER: Just on Bob's point. And of course
18 this is anecdotal, but we maintain a SNF in our hospital and
19 we believe the patients are different. In the freestanding
20 SNFs in our community we are being told by those nursing
21 homes please do not close your SNF because we can't take
22 care of those patients. Our physicians believe that there

1 is a group of patients who just aren't ready to go out to a
2 freestanding SNF.

3 When Sally and I and others did the LTCH visits
4 whenever that was, last year or the year before, we heard
5 from some of the physician at the LTCHs that there was
6 nowhere else to send these patients now that the hospital-
7 based SNFs had closed because they didn't consider the
8 freestanding SNFs really capable.

9 So I don't know that we have the answer on that
10 particular point yet. My experience though tells me there
11 is something different. Of course, we're moving in a right
12 recommendation by recommending a new classification system.
13 The problem is as the years unfold, it's never happened.

14 MR. HACKBARTH: Now that I think back on the
15 history, I think actually we recommended a differential
16 update maybe two years in a row. That was premised on the
17 hunch that, in fact, the patients were different. And then
18 we did a little bit of research and looking around to see
19 if, in fact, we could verify that hunch in any analytic way.
20 And we came up with short in being able to back that up, is
21 my recollection.

22 DR. MILLER: That's my recollection as well, and

1 anybody on the staff who can remember this better should
2 speak up.

3 But there was another layer to it that we had some
4 other work done. There was a really interesting finding in
5 that that even further complicates the point. If you look
6 at the distribution of patients who go to a hospital-based
7 SNF versus a freestanding SNF, what you find is that there's
8 a very stark sorting of patients between them. And the ones
9 who go to hospital-based SNFs tend to be younger. They tend
10 to have a spouse available to them. They tend to be more --
11 they have rejected do-not-resuscitate orders, that type of
12 thing. It's stuff that's not captured by the case mix, but
13 clearly a sorting process that goes on between the hospital-
14 based and the SNFs. So these are people who are more likely
15 to have a short stay and get out and be --

16 MR. HACKBARTH: Now was in the context of trying
17 to compare the different settings for -- was it knee and hip
18 patients?

19 DR. MILLER: No, this was something even further
20 back.

21 MS. THOMAS: We were just doing a comparison of
22 the characteristics of patients who go to hospital-based

1 SNFs versus free-standing.

2 DR. MILLER: I also wanted to say one other thing
3 about a vehicle. You were using the word policy vehicle --
4 and I want to make sure I get this right, Sally. We also
5 have another analysis coming on deck for the spring cycle
6 that's going out into the marketplaces. We're trying to
7 pick marketplaces where hospital-based SNFs have kind of
8 hung around, gone in large numbers, that kind of thing, and
9 trying to figure out whether there are structural
10 differences on what drives those changes.

11 So we're going to try another pass at this.

12 That's more of an analytical vehicle, as opposed to a policy
13 vehicle, which I wasn't quite sure what you were --

14 MR. MULLER: Obviously payment differential is a
15 policy vehicle as well.

16 But if, in fact, they are an extension of the
17 hospital population, for the reasons that Nick suggested,
18 very acute but not as acute as your average hospital
19 patient. So in that sense it becomes standard. But if the
20 payment rate is so much less within a cost structure that
21 looks more like a hospital structure, you expect pretty high
22 negative margins.

1 And since the LTCHs have the 25-day minimum and so
2 forth and by what Mark is saying -- I don't remember these
3 numbers -- what the average length of stay is in hospital
4 SNFs. So it may be -- it's shorter.

5 So they just may be people transitioning out of
6 the hospital to other settings, including maybe freestanding
7 in due time.

8 I'm just suggesting that if we're -- at very high
9 negative margins they're going to keep closing, and whether
10 that's the right place to be, even granting Bob's point.
11 They may be too expensive vis-a-vis -- they're more
12 expensive than they're currently getting. But they may be
13 less expensive to run them than either backing up the
14 hospital if you don't have alternatives. They probably
15 wouldn't go into LTCHs with the 25-day limit.

16 MR. HACKBARTH: Another additional complication in
17 this picture, as some people around the table have reminded
18 us from time to time, the capabilities of a SNF are not
19 fixed and they vary from community to community, in part
20 dependant on what other kind of resources exist in that
21 community.

22 So we talk about these labels as though they're

1 really defined, well-defined units with very predictable
2 capabilities. And that isn't always the case either. It is
3 a very complicated area.

4 Other questions for Kathryn, or comments?

5 MS. DePARLE: I was toying with what you said,
6 Glenn, and thinking that what we're really describing here,
7 from what Nick said anecdotally to what Ralph and others
8 have said, and what we've talked about for the last several
9 years and the reason why we made the differential update
10 recommendation, is we have a hunch that clinically this is a
11 level of care that is needed for certain beneficiaries. And
12 it appears that in some communities it's occurring in
13 hospitals and in some communities it's occurring in
14 freestanding SNFs. In some communities it may be in an LTCH
15 bed, and maybe even in home health in some communities.

16 And so is there some way, this goes back to our
17 long-standing recommendation that what should be happening
18 here is sort of a post-acute care, post-acute assessment and
19 more of a -- in each community, however you would define
20 that, there should be that level of clinical care available
21 for a patient who is assessed to need it. But it doesn't
22 necessarily have to be in every hospital.

1 That said, I'm very troubled, as I'm sure everyone
2 else is, by data that would suggest that we have hospitals
3 trying to do this with 85 percent negative margins. I just
4 don't see how we can do that.

5 So I, at least, would be in favor of having a
6 separate update or a differential update for the hospital-
7 based facilities. It's not perfect. It's not where the
8 system should be. But in the absence of anything more
9 comprehensive that would begin to solve this a better way,
10 I'm just very troubled by not acknowledging that and setting
11 it fourth. Because I do think people look at our reports
12 and would get from that that we're concerned about the
13 existence of this service in some communities.

14 Maybe you think we have enough information to do
15 that. I don't know.

16 DR. REISCHAUER: But if we went just by the
17 numbers, what we'd recommend is no update except for
18 hospital-based. And in hospital-based a 90 percent update.
19 And that would get them up to a 5 percent margin or
20 something.

21 I ask you how our credibility would look with that
22 recommendation versus the one we were considering?

1 MR. SMITH: I supported the differential update
2 that Nancy-Ann is suggesting both times that we did it. It
3 seemed, to me, to make sense because we did suspect that
4 they were either in a different line of business or treating
5 a different group of beneficiaries. Neither of those
6 assumptions appears to be true.

7 But what may matter a lot, and we don't know
8 enough at this point, but maybe we'd need a plan to find it
9 out. What may matter a lot is context and what the
10 marketplace for providing post-acute care looks like in a
11 place that does or doesn't have a hospital-based SNF? Or
12 what are the characteristics of the rest of the marketplace
13 that cause a hospital to shut one down, as opposed to a
14 decision by a differently situated hospital to keep one
15 open?

16 I think before we can return to making a
17 differential update recommendation we need to try to figure
18 out more about what we're trying to preserve and protect
19 here. There's little evidence that we're trying to preserve
20 a different line of work. But there may be some evidence,
21 we think but we're not sure, that we may be trying to
22 preserve access to a certain kind of post-acute care in a

1 marketplace that doesn't offer up a sufficiently rich mix of
2 alternatives.

3 I'd like to see if we can't figure out how to do
4 that before, as Bob says, we say something: A, that we've
5 said twice before and it didn't make much difference.
6 Hospital-based SNFs continued to close rapidly and at the
7 data suggest continued to operate at very large negative
8 margins; and doing it again without having a more compelling
9 reason than we have. Our credibility, such as it is, would
10 probably be impaired. But also. we wouldn't be able to
11 figure out how to talk about it. We couldn't write about it
12 because we wouldn't know how to make sense out of it.

13 DR. MILLER: We do have this study to go out and
14 look, I think it gets at it a little bit of what you were
15 talking about.

16 Just one other idea that we just talked about at
17 the staff level and sort of have it churning around is
18 whether you start thinking about moving away from a per diem
19 here and start thinking about more of an episode-based
20 payment. But this is just talk at this point. We're still
21 looking at a whole range of ideas here.

22 DR. SCANLON: I was going to add, in terms of

1 looking at this, I think it also would be important to look
2 at the hospital stays of these two groups of people, those
3 that end up in a hospital-based SNF versus those that end up
4 in freestanding, to be sure that they are comparable in
5 terms of the type of services being received and the length
6 of time that they're there. Because that's a piece of this,
7 as well.

8 Especially if you take -- Mark's mentioning
9 episode, look at the overall episode not just the post-acute
10 episode.

11 MS. DePARLE: And readmissions as well, I think.

12 MR. SMITH: The other thing that might be useful,
13 we might learn something about the distribution of the
14 negative margins. Do they vary in any significant way
15 depending on context? And the alternatives available in
16 that local marketplace.

17 And are there some hospital-based SNFs that don't
18 have very sharp negative margins? And if so, what can we
19 learn that would explain them?

20 MR. HACKBARTH: We look at the departures as
21 potentially an indicator of a problem. That implicitly
22 assumes that the starting point was the right level. I

1 remember when Jack Rowe served on the Commission several
2 years ago when we were talking about this. He said maybe
3 the starting point is not right, that people went into this
4 line of business to take advantage of opportunities to
5 shorten inpatient stay and maximize their payment pre-
6 transfer policy rules.

7 And so you would expect some natural readjustment
8 of supply as those issues have been addressed. So maybe
9 we're going down towards the right level of supply of
10 hospital-based SNFs and we shouldn't be fretting about
11 departures.

12 DR. MILLER: That reminds me, and I forgot this
13 point. At the time we were having that discussion there was
14 also -- I think I'll get this wrong. But isn't there like a
15 three-year period where you kind of got cost reimbursement
16 to set your base, and then they rolled into PPS?

17 There was some arrangement like that, as I recall,
18 pre-PPS.

19 MS. LINEHAN: You did some work a few years ago
20 where you looked at the characteristics of hospital-based
21 SNFs that left. And I can't remember the array of
22 characteristics. But they were more likely to be recent

1 entrants into the market. They were more likely to be for-
2 profit. There were a couple of other things.

3 DR. WOLTER: I was just going to say that I do
4 think, kind of to Bob's comment, you wouldn't probably go to
5 a 90 percent recommendation update for a lot of reasons.
6 But one of them is that there still is some financial value
7 in having that setting in a hospital, even with the transfer
8 rule coming into play. There's still some value for
9 patients who might otherwise go on the long side of length
10 of stay. I think people put that into they're analysis when
11 they make the decision as to whether or not to stay with a
12 hospital-based SNF. So it's probably important to make that
13 point.

14 Having said that, I'm quite confident that in some
15 communities the patients that are being care for there are
16 patients who do have a little different profile than those
17 who would go out into the freestanding SNFs. I wish we
18 could get data that would show that.

19 MR. DeBUSK: Is that called the LTCH?

20 MR. HACKBARTH: Any others?

21 Okay, thank you, Kathryn.

22 Next, Sharon is going to present on home health.

1 MS. CHENG: Okay, last payment adequacy
2 presentation of the day

3 In the next couple of minutes that I have with
4 you, I'll fill in the parts of the framework for home health
5 services that we began to discuss at our last meeting.

6 Today I'll have geographic access, changes in the volume of
7 service, financial performance, and changes in the rate of
8 growth in the cost of producing an episode of home health.

9 The first piece of the framework that I have for
10 you today is access. We have two questions that we
11 typically here. One is do communities have providers? And
12 then are beneficiaries getting care?

13 Last month we looked at whether or not
14 beneficiaries had problems accessing care. We used the
15 CAHPS survey for that and we found that 90 percent of
16 beneficiaries reported little or no difficulty getting care.
17 This month, thanks to some terrific work by Sarah Kwon, we
18 have a look at geographic access. What we're asking here is
19 do communities have providers that are willing to serve the
20 beneficiaries there?

21 The bright yellow that covers most of the map is
22 the color code for a zip code that was served by two or more

1 home health agencies in the past 12 months. The orangey-red
2 color are areas that were served by one home health agency
3 in the last 12 months. So it's the light blue areas within
4 the map that were not served by any home health agency in
5 the past 12 months.

6 Although some of the light blue areas cover quite
7 a few square miles, they are very sparsely populated. 99
8 percent of all beneficiaries live in yellow or orange areas
9 on this map.

10 This zip code analysis is one that I've brought
11 you before and I've got to share the caveats to it. The
12 fact that a home health agency served a beneficiary in one
13 corner of a zip code does not necessarily suggest that the
14 home health agency would be willing to serve all of a zip
15 code that might be very large or might be geographically
16 diverse.

17 On the other hand, for some of the very sparsely
18 populated areas, if no beneficiary in that community sought
19 care within our window, then there would be no service
20 recorded even though there might be a home health agency
21 that's willing to serve that community.

22 You can see that many of the red areas are in

1 rural areas. As you recall, we did use CAHPS again to see
2 if there were differences in the access reported by
3 beneficiaries living in rural and urban areas. What we
4 found actually was that rural beneficiaries reported better
5 access to care than their urban counterparts. I only
6 mention this to suggest that living in a red area on this
7 map is not necessarily indicative of access problems for
8 home health.

9 I think when we look at this map overall, what it
10 does suggest is that almost all urban and rural communities
11 have a home health agency, at least one, and many have two
12 or more.

13 The second piece of the framework that I have for
14 you is some information on the two most recent years of the
15 volume of home health services. We have a couple of
16 different ways we think about this. We look at the number
17 of users. That's increased from 2003 to 2004. The number
18 of 60-day episodes that are provided to those beneficiaries
19 also increased. As you could see, the relationship between
20 those two numbers has changed a bit. So we go from an
21 average of 1.6 episodes per user to 1.7 episodes per user.

22 What this suggests is that home health agencies

1 are providing a second or subsequent episode to
2 beneficiaries more frequently in 2004 than they did in 2003.
3 This is the continuation of a trend that's been continuing.
4 There were 1.5 episodes per beneficiary just three years ago
5 into 2001.

6 The number of visits per episode, which is another
7 way we think about the volume of services, remained
8 unchanged between 2003 and 2004.

9 As the number of visits per episode held steady,
10 the quality of outcomes that are produced in those episodes
11 stayed the same or improved. This is something we went into
12 in more detail last month. Just to touch on it, indicators
13 of improvement in functioning -- ability to walk, to bathe,
14 to dress -- continue to show slight improvement. Indicators
15 of the use of hospital or ER services have remained
16 unchanged.

17 The next part of the framework that we have is
18 information on the financial performance of home health
19 agencies. And our base year for this data is 2004. So on
20 the screen I have the number of HHA's, freestanding home
21 health agencies, in our sample and then the margin by group.
22 The overall margin for aggregate home health agencies is 16

1 percent. And then I've broken it down by some groups that
2 you've seen in the past.

3 I characterize the agencies by their caseload
4 rather than their location, so urban agencies serve that
5 population. A mixed agency tends to serve 60 or 70 percent
6 rural beneficiaries and the rest are urban. Then rural
7 agencies are serving purely rural beneficiaries.

8 We also look at the type of control, voluntary,
9 private, or government controlled agencies. I've also
10 broken it down by size. Again, the way I think of size here
11 is I take the number of episodes that the agency provided in
12 a year and then I've broken that into quintiles. So the
13 very small agencies, the first to 20th quintile there,
14 ranging to the largest agencies, the 81st to 100th quintile.

15 The patterns that we see here in the relative
16 margins are very similar to patterns that we have seen in
17 the past several years when we compare these groups.

18 So starting then from 2004, I also go through the
19 exercise of looking forward and seeing if we can get to
20 2006. So I take the changes that have occurred in the
21 payments into consideration. The first change was the
22 update of 2.3 percent that they had to their base payment in

1 January 2005. In that year there was also an increase in
2 the pay out of outlier payments. Then in April of 2005 the
3 rural add-on expired.

4 In January of 2006 they will receive an update to
5 their base payment of 2.8 percent, and they will also begin
6 a transition to a new definition of metropolitan areas.
7 This transition to the new Metro areas will be budget
8 neutral once it is applied to all home health agencies. We
9 include it in our thinking because it has the effect of
10 raising the base payment for rural agencies slightly more
11 than average and for urban agencies slightly less than
12 average.

13 The change to the new metropolitan areas will be
14 phased in over the next two years to smooth some of the
15 volatility in the wage index.

16 In addition then to looking at the changes in
17 payments between 2004 and 2006, we gather information about
18 the changes that are likely to occur in the costs. What
19 we've seen here is that since the first full year of the
20 PPS, that was 2001, the increase in the cost of producing an
21 episode of home health has changed very little. There has
22 been an average annual cost growth of 0.6 of 1 percent.

1 But again the theme that we have in home health is
2 that everything varies. So within this widely varied
3 industry, we have widely varied cost growth. For example,
4 one-quarter of all agencies over this same time period had
5 an average annual cost growth of 3.4 percent. Another
6 quarter of home health agencies saw their costs actually
7 decline at an average annual rate of 0.7 percent.

8 We looked at some of the other variations in cost
9 growth. Generally government agencies had the greatest rate
10 of cost growth, voluntary agencies somewhat less than that,
11 and private agencies actually generally saw declines. Cost
12 growth did not appear to be related to the size of the
13 agency. In each case, every time we grouped these agencies
14 together, there's more variation within the group than there
15 tends to be among the groups.

16 Our model here, as in elsewhere, brings the
17 changes in costs and the changes in payments together as we
18 look forward. So given the high margins in 2004, the impact
19 of the positive updates and other payment changes that have
20 occurred, and the very slow historic cost growth, we would
21 project that the margins for this sector would rise slightly
22 into 2006 to a 16.9 percent margin.

1 To sum up, bringing all these factors together
2 then, we have seen access both ways that we think about it
3 to be generally good. We do see that most communities have
4 providers. We observed last month that providers are
5 entering this sector rapidly. There's been 500 entrants
6 over the past 12 months and there have been about 1,000
7 entrants over the past couple of years.

8 Quality continues to improve slightly. Volume of
9 services is increasing. The current margin that we measure
10 is 16.0 and we project the margin to rise to 16.9. Part of
11 that reflects historic slow cost growth in the per episode
12 costs.

13 All of these factors together tend to suggest that
14 agencies should be able to accommodate cost increases over
15 the coming year without an increase in the base payment.

16 In current law, if Congress does nothing, home
17 health agencies will receive a full market basket update in
18 2007. The draft recommendation that we have here reflects
19 what we have done in this sector in the past when the update
20 factors have looked very similar and we, on the screen, have
21 the recommendation that Congress should eliminate the update
22 to payments for home care services for calendar year 2007.

1 As we have noted, though we have made this
2 recommendation in the past, they have received positive
3 updates for the past two years.

4 The spending implication of implementing this
5 would be a decrease then relative to current law, and we
6 project no major implications for beneficiaries or providers
7 because the factors suggest that agencies should be able to
8 tolerate price increases without an increase to base
9 payments.

10 Moving then just briefly from our discussion of
11 the level of payments to the distribution of payments, we
12 continue our thinking on whether or not we're moving the
13 dollars around appropriately within the sector. This is
14 just a summary of our thinking to date. We have research
15 that suggests we have pretty significant product changes
16 that occurred between the time they set up the payment
17 system and the payment system that's operating today. The
18 current home health product includes fewer visits than it
19 did when they set up the payment system and a much higher
20 proportion of therapy than it did when the system was
21 created.

22 An overuse of therapy is consistent with the

1 incentives of the current payment structure. An agency
2 receives about \$2,500 additional for an episode that hits
3 the therapy threshold versus an episode for functionally and
4 clinically the same patient that receives nine or fewer
5 therapy visits.

6 We've also measured in the past the average
7 minutes of service within payment groups and we found that
8 those average minutes per episode are too varied if they're
9 related to costs to suggest that we've got homogenous cost
10 within our payment groups.

11 And finally, as we discussed earlier this year in
12 our cycle, we found a small but statistically significant
13 relationship between case mix and margin, again with all the
14 caveats that our model was not particularly strong in
15 predicting costs generally.

16 Finally, this is kind of to close a loop for the
17 commissioners and for the thinking, last year we proposed
18 further research on some beneficiary characteristics that we
19 had identified as being outside the current payment
20 adjustment but they could be related to costs. And if they
21 were related to costs, it might make it difficult for
22 beneficiaries with those characteristics to access care.

1 So we were able to test this list of four
2 beneficiary characteristics while we were running that model
3 that we used earlier this year. So what we did is we looked
4 at the case load of home health agencies. We used the OASIS
5 patient assessment to measure these characteristics that are
6 outside the payment system and then we compared home health
7 agencies that had a very large caseload proportion of
8 patients with these characteristics to see whether their
9 profitability was related to that caseload.

10 Again we found that there was no statistically
11 significant relationship between having a large proportion
12 of patients with these characteristics and your
13 profitability, absolutely with the same caveat, the model
14 isn't very strong but I wanted to touch base that we are
15 thinking about these characteristics and we have done a
16 little bit of testing on them.

17 So with that, I'm certainly ready to take your
18 questions on either the distribution questions or the level
19 of payment questions.

20 DR. MILSTEIN: Thank you. That was terrific.

21 Do we have any basis for interpreting the
22 significance of the annual 7 to 8 percent upward creep in

1 the number of episodes per beneficiary? There are obviously
2 a number of interpretations of that upward creep, some more
3 along the lines of sicker patients. Others implying perhaps
4 an adaptation to the payment system by the home health
5 providers.

6 Do we have any evidence that might shed light on
7 which of those two interpretations, perhaps a third
8 interpretation, might best explain this continued upward
9 creep in the number of episodes per beneficiary?

10 MS. CHENG: I think our conclusion would be that
11 it's probably both of those influences going on. When the
12 payment system was set up CMS acknowledged that as soon as
13 you create episodes, then there would be an incentive to
14 deliver the same amount of care and stretch it into two
15 payment episodes.

16 One of the things that we have observed, however,
17 is that the average number of visits per episode has been
18 really flat. So they aren't taking the same number of
19 visits and just stretching them over two payment episodes.
20 There does seem to be -- they're holding the average number
21 of visits steady.

22 I know that CMS is looking at second and

1 subsequent episodes as a particular phenomenon. One of the
2 things that they're trying to determine, too, is what kind
3 of patient characteristics, who's using these second and
4 subsequent? Are they a different group of people? So we'll
5 have a little bit more data that. I'm not sure what I can
6 bring you by January to tease those two influences apart.

7 MR. HACKBARTH: Just to follow on that, on page
8 three is it the episodes or the episodes per user that are
9 catching your eye? It looks like that's driven by the
10 number of users. I assume users is the base unit. And
11 since users may have more than one episode, that could
12 increase the episodes. But it's the user growth that is the
13 one that's gone up.

14 Am I interpreting the table correctly?

15 And then the historical context for that is that
16 we had a big decline in the number of users with the advent
17 of the cost limits and that persisted through the early days
18 of the new PPS system and then it started going up again.
19 That doesn't mean that it's good or bad but that's the
20 historical pattern, like a U-shape.

21 MS. CHENG: Right. The number of users has been
22 increasing but also the average episodes per user. They're

1 both going up. Not a lot.

2 MR. HACKBARTH: 1.7 to 1.7.

3 DR. REISCHAUER: Are these numbers consistent?

4 Because if the number of users goes up by 6 percent, by
5 definition the episodes have to rise because every user has
6 to have an episode.

7 MS. CHENG: Right, but the number of episodes is
8 rising faster.

9 DR. REISCHAUER: So then the user per episode
10 should go up 1 percent. There's a rounding issue, I'm sure.

11 MS. CHENG: I can get you more precise numbers.
12 The number of episodes per user going up is also consistent.
13 One of the numbers I didn't put up here is length of stay.
14 I measure the number of days between being admitted to home
15 care and being discharged from home care. And that's been
16 increasing as well.

17 So the average length of stay is actually starting
18 to approach 60 days, which is suggesting that a lot of
19 people are getting two episodes of payment during their stay
20 of home health.

21 DR. REISCHAUER: 1.7 is 6 percent higher than 1.6,
22 so it's probably 1.54.

1 DR. SCANLON: [Inaudible.]

2 MR. HACKBARTH: Now that we've resolved that.

3 MS. CHENG: What I'm taking away is don't over
4 interpret the change here.

5 DR. MILSTEIN: I think what I'm asking is is there
6 a way of shedding more light on the implications of this
7 annual upward creep of -- Bob was saying -- 6 or 6.5 percent
8 a year, with respect to the number of episodes per
9 beneficiary?

10 DR. MILLER: Sharon, a couple of things on this.

11 I suspect that there's not as much change here but can we
12 calculate the difference in case mix over this time looking
13 at the distribution of cases across the HHRGs?

14 But I suggest probably if there's changes in the
15 mix of patients, it's probably inside those categories as
16 opposed to across those categories.

17 MS. CHENG: We have seen the average case mix go
18 up a little bit. Again it's this incremental...

19 DR. MILLER: Not in the 6 percent range though,
20 for example?

21 MS. CHENG: What I'm pulling off the top of my
22 head is we started off with an average case mix of about

1 1.2. And the last time I measured it in 2003 it had risen
2 to 1.3.

3 So yes, you're seeing the case mix increase over
4 this time, too.

5 DR. MILLER: So maybe that's one thing we can
6 calculate.

7 A second thing is actually just a different
8 version of the same question. Can we disaggregate the
9 growth in the episodes per user by the different HHRG
10 category? So you can see it's these HHRGs that are growing
11 and not these. Or is it uniform and all of them are
12 growing?

13 Just to get underneath it a little bit more to
14 Arnie's point. I'm not sure how much light that sheds on
15 it, but that's working from the data that's available as
16 opposed to what's a perfect answer to the question.

17 MR. HACKBARTH: It would also be interesting to
18 see more years. We've got two data points, two consecutive
19 years. I don't know how much year-to-year variation there
20 is in these numbers.

21 MS. CHENG: In 2001 it was 1.5.

22 MR. HACKBARTH: Okay.

1 Other questions or comments for Sharon?

2 DR. WOLTER: I just wanted to note that this is a
3 rare instance in recent years where Montana is shown as a
4 blue state.

5 [Laughter.]

6 DR. WOLTER: I did want to just pass on a few
7 comments. I checked with some of our home health folks back
8 home, and I think that the discussion about the situation in
9 rural areas may be a little less rosy than has been
10 portrayed. You can tell from the map that we have a number
11 of counties, it would be at least 25 percent of our counties
12 and a larger number of square miles, where there's not a
13 home health service. I don't know how much that would be
14 replicated in other rural parts of the country.

15 We've had no new agencies enter our markets since
16 the year 2000 and have had a number closed. I don't know
17 the exact number.

18 Also, there's concerns back home being raised
19 about the fact that our margin data is only from the
20 freestanding facilities. And in rural states my
21 understanding is there's a larger percentage of hospital-
22 based home health agencies than there are freestanding. At

1 that's certainly true in Montana where about two-thirds of
2 the home health agencies are actually hospital-based. So we
3 don't really have any information at this point about how
4 they're doing margin-wise.

5 They are concerned that we don't have the access
6 we might wish. The transportation costs across the larger
7 areas they have to travel, of course, have gone up
8 significantly recently. And so they have some concerns
9 about feeling a little less rosy about some of those rural
10 issues.

11 They had a few other things, Sharon, that I'll
12 just send along to you that we can talk about offline.

13 MR. HACKBARTH: Others?

14 Okay. Thanks, Sharon.

15 Our final presentation takes us away from payment
16 adequacy, you can hold your applause, to lab utilization.

17 MS. KELLEY: In October we discussed concerns that
18 Medicare is not paying accurately for clinical lab services.
19 As you'll recall, Medicare's payments are based on charge
20 data from 1983 and the method for determining payments for
21 new services is inefficient and likely to generate
22 inaccurate rates. Improving Medicare's payment methodology

1 is important because the clinical lab benefit costs almost
2 \$6 billion in 2004 and has grown an average of 9 percent per
3 year.

4 Today, Ariel and I will present some information
5 on the lab industry and on the use of lab services by
6 Medicare beneficiaries. We'll also update you on some
7 issues related to quality concerns in Medicare certified
8 labs.

9 As of August 2005 there were more than 192,000
10 labs in the U.S. The number of labs has grown on average
11 about 2 percent per year over the last decade. Physician
12 office labs, as you can see, account for about half of all
13 labs but they finish a much smaller proportion of total lab
14 services.

15 Most physician office labs perform only waived
16 tests and/or certified microscopy tests. As you can see
17 here, the proportion of physician office labs certified to
18 perform only waived and/or microscopy test has increased
19 steadily since 1995.

20 Waived tests are defined by the FDA as simple lab
21 tests and procedures that can be performed at home or that
22 are so simple and accurate as to make errors unlikely.

1 There are 42 codes that are classified as waived including
2 dipstick urinalysis for glucose and white blood cells and
3 spun hematocrit blood test for anemia. Certified microscopy
4 procedures are 12 codes performed with a microscope by a
5 physician, a dentist, or a mid-level practitioner that are
6 considered moderately complex.

7 Medicare's payment rates for waived and microscopy
8 tests generally are lower than for more complex tests but
9 certification requirements are far less rigorous. Labs that
10 are certified to perform waived and microscopy tests are not
11 subject to routine inspections.

12 The independent lab sector is highly concentrated
13 with the two largest independent lab companies, Qwest and
14 LabCorps controlling an estimated 60 percent of the
15 independent lab market and getting bigger. In November
16 Qwest completed a \$934 million acquisition of LabOne request
17 which had been the fourth largest independent lab company.

18 Over the past few years, the overall climate in
19 the lab industry was quite bright, largely due to the
20 decline in managed care. From 1998 to 2003 the combined
21 revenue in the independent lab industry grew by an estimated
22 7 percent per year. But industry analysts expect that the

1 industry will face increasing price pressures in the future.

2 The MMA imposed a five-year freeze on updates to
3 Medicare's payments for clinical lab services. States are
4 struggling with their own Medicaid budget issues and private
5 payers are now attempting to contain premium increases,
6 which may result in constraint payments for lab services.

7 Consolidation in the Independent sector is
8 ongoing.

9 Now to quality. Prior to 1988 only labs that
10 engaged in interstate commerce were regulated by the Federal
11 Government, so many labs went unregulated. Under the
12 Clinical Laboratory Improvement Act of 1988, or CLIA, CMS
13 now certifies all providers of clinical lab services based
14 on the complexity of the testing they conduct. For labs
15 performing moderate or high complexity tests, other than the
16 specified microscopy procedures I mentioned earlier, CLIA
17 specifies quality standards for proficiency testing, patient
18 test management and quality control and assurance. These
19 facilities are subject to routine inspections and labs
20 performing high complexity tests must meet stringent
21 personnel requirements.

22 Lab performance improved substantially during the

1 first years following the implementation of CLIA. According
2 to CMS, the proportion of labs showing no failures in
3 proficiency testing climbed from 69.4 percent in 1995 to
4 87.4 percent the following year.

5 But in recent years new concerns have arisen about
6 the quality of care provided in labs that furnished only the
7 waived and microscopy tests. In 1999 state surveyors in
8 Colorado and Ohio initiated onsite inspections of a random
9 sample of labs certified to perform only those procedures.
10 You'll recall that they normally have no routine
11 inspections. The surveyors found significant quality
12 problems in over half of the labs. In 2001 CMS went on to
13 survey 436 labs in eight additional states and found similar
14 quality issues.

15 As a result, beginning in April 2002, CMS began
16 conducting annual visits to a small percentage of labs
17 performing the simple tests. The effects of these visits on
18 overall quality is not yet known.

19 More recently there have been reports in the press
20 of quality problems in some hospital-based labs. This was
21 the topic of a series of Congressional hearings last year.
22 GAO was subsequently asked to review the requirements for

1 lab quality and to assess the effectiveness of the
2 certification process and a report is expected early next
3 year.

4 Ariel is now going to talk about our analysis of
5 Medicare beneficiary use of clinical lab services and future
6 work we have planned.

7 MR. WINTER: The next several slides are based on
8 our analysis of Medicare claims data for services paid under
9 the laboratory fee schedule. Some lab services are paid
10 under the physician fee schedule. These are generally those
11 that involve pathologist's time. These were excluded from
12 our analysis.

13 Although there are over 1,000 tests in the lab fee
14 schedule, the volume of test is fairly concentrated. This
15 chart shows that the 10 highest volume tests accounted for
16 55 percent of Medicare volume in 2003 and half of spending.

17 According to OIG in 1997 over half of the test
18 codes were billed fewer than 1,000 times. The most
19 frequently billed service on the lab fee schedule is
20 venipuncture, which is actually not a test. It accounts for
21 almost one-fifth of total volume but only 6 percent of
22 payments. This is because it has a very low payment rate of

1 \$3 per blood draw.

2 Physician offices that don't have labs can bill
3 for venipuncture. They can draw blood that is sent to an
4 outside lab for testing. About half of venipuncture
5 services are provided by physician offices that don't have
6 labs.

7 If the test has an asterisk next to it on the
8 slide, this indicates that the test has been growing faster
9 than 10 percent per year between 2001 and 2003. And that's
10 volume growth we're talking about here.

11 The second test on the slide, which is a type of
12 complete blood count test, grew by 25 percent per year. It
13 accounted for a higher share of payments in 2003 than any
14 other test, about \$450 million.

15 It's important to mention that many of the tests
16 that are growing rapidly are recommended by clinical
17 guidelines for the treatment of certain chronic conditions.
18 For example, complete blood count tests and metabolic panel
19 tests are quality indicators for congestive heart failure,
20 and the lipid panel and hemoglobin tests are quality
21 indicators for diabetes. It could very well be that much of
22 the volume growth we've seen represents clinically

1 appropriate use of tests and this is something we plan to
2 investigate further.

3 We also looked at the volume growth of various
4 categories of tests compared to the growth rate for all
5 test, which was 7 percent per year between 2001 and 2003,
6 and that's the red bar at the far right on the slide.

7 The bar at the far left represents screening tests
8 mandated by Congress prior to the Medicare Modernization
9 Act, and these include pap smears and fecal occult blood
10 tests. These tests increased by 10 percent per year between
11 2001 and 2003, and much of this growth is probably
12 desirable.

13 The next bar shows waived microscopy tests which
14 are often done in physician offices. These include
15 prothrombin time lipid panel hemoglobin and urinalysis
16 tests. These grew by 11.5 percent per year.

17 New tests that were added to the lab fee schedule
18 in 2001 experienced very rapid growth of 28 percent per
19 year. This category includes new types of bacterial blood
20 culture tests, immunological tests and genetic tests. It's
21 not surprising that new tests are growing quickly because
22 they started from a small base. It could be that new tests

1 are substituting for older tests and this is something we'd
2 like to explore further.

3 Medicare spending for all tests, which is not
4 shown on the slide, grew by nearly 10 percent per year
5 between 2001 and 2003, compared to 7 percent annual growth
6 in volume, which is the red bar on the slide. Because
7 payment rate stayed constant during this period, the fact
8 that spending grew faster than volume suggests that there
9 was a shift from lower paid tests to higher paid tests.

10 We then examined the distribution of volume by
11 type of test. Despite their rapid growth, new tests
12 accounted for less than 1 percent of total test volume in
13 2003. Screening tests were also 1 percent. Waived and
14 microscopy tests represented over one-fifth of total volume.

15 We also looked at geographic variations in the
16 number of tests per beneficiary. The national average was
17 almost 15 tests per fee-for-service beneficiary in 2003 and
18 there was a modest spread around this mean. The Mountain
19 states had the lowest use rate of about 11 tests per
20 beneficiary, and the New England states have the highest use
21 rate of almost 17 tests per beneficiary. The ratio of the
22 New England rate to the Mountain rate is 1.47.

1 We found much greater variation at the state
2 level, as you might expect. The ratio of the highest use
3 state to the lowest use state was 2.17 in 2003.

4 This slide shows geographic variations in the
5 growth of tests per beneficiary. There was much more
6 variation in growth rates than in the number of test
7 provided, which is what we saw in the previous slide.

8 For the U.S. overall the volume of tests per
9 beneficiary grew by 4.4 percent per year between 2001 and
10 2003. The West North Central states, in the middle of the
11 slide -- which include Iowa, Kansas, Minnesota, Missouri and
12 the Dakotas -- had the lowest growth rate of 2 percent per
13 year. The East South Central states, also in the middle of
14 the slide, had the highest growth rate of 6.6 percent per
15 year, more than three times the rate of the lowest growth
16 region. This region includes the states of Alabama,
17 Kentucky, Mississippi and Tennessee.

18 There does not appear to be a correlation between
19 regions with the highest growth and the regions with the
20 most number of tests in 2003. We plan to look at whether
21 geographic areas that provide more tests have better health
22 outcomes and we'll be working with the researchers at

1 Dartmouth, including Elliott Fisher, on this question.

2 We plan to examine several issues in the future.

3 We're going to look at changes in volume of spending by type
4 of lab, hospital-based, independent and physician office.

5 We'll be looking at oversight of lab quality. Whether
6 there's a relationship between the number of test provided
7 and the number of outcomes. And how Medicare rates compare
8 to rates paid by other payers. We'll also be exploring
9 policy options, including ways to improve the current
10 payment system and alternative payment method such as
11 competitive bidding.

12 We'd be happy to take any questions.

13 MR. BERTKO: Ariel, just a quick added suggestion
14 for your explaining some of these. You may look at the risk
15 adjustment for the health status of the people there. The
16 East South Central is what I have jokingly referred to as
17 the fried food belt and may, in fact, have some explanatory
18 power there, although I doubt it's this much.

19 MR. DURENBERGER: Thanks very much.

20 Thanks for the comment at the end about trying to
21 relate all of this to outcomes because I was really
22 confused, as maybe others were, too.

1 But maybe in a real simple way, explain to me the
2 consequence of low quality generally. You said something
3 about they go in and investigate these labs and half of them
4 are not meeting some standard.

5 Is this an overuse issue? Or is this billing
6 that's for services not performed? What is actually going
7 on when we talk about quality?

8 MS. KELLEY: The surveyors found in the labs that
9 were performing the more simple tests a number of problems
10 mostly related to the way the tests were performed. The
11 requirements for the waived test are simply that they
12 perform the test to the manufacturer's instructions. Many
13 of the labs were found not to have manufacturer's
14 instructions on site. Many of them were found to not be
15 following them, even if they were onsite. Some of the labs
16 were found to be providing services that they were not
17 certified to perform.

18 So all of the quality issues were related to
19 actual procedures and processes within the lab, as opposed
20 to other issues related to --

21 MR. DURENBERGER: Is there a way, with regard to
22 some of these, to take that into deciding whether or not a

1 properly administered test would have prevented an
2 expenditure which Medicare is having to pay for? If you
3 follow the question. In other words, what's the financial
4 consequence of not following the rules and so forth?

5 MS. KELLEY: I'm not quite sure how to --

6 MR. WINTER: One thing we'll be looking at is
7 whether there's a relationship between use of labs in
8 different regions and outcomes in those regions, things like
9 survival rates, readmission rates, those kinds of things.

10 We might also want to look at whether there's a
11 relationship between areas that use lots of labs generally
12 and areas that do very well in terms of quality indicators
13 that involve lab use, like lipid testing for diabetics and
14 glucose testing, that sort of thing.

15 In terms of quantify the financial impact in terms
16 of downstream expenditures, it would be a tougher lift but
17 we can see what we can do there.

18 DR. REISCHAUER: I wonder if in a way we're
19 searching what's optimal lab use? Clearly we are, in some
20 gross sense, underpaying labs. There seem to be a lot of
21 tests going on and they're growing at a very rapid rate so
22 that doesn't seem to be a problem. But the question is how

1 much variation should there be across the country?

2 One way is to look at Dave's area and see what the
3 distribution is there. I was wondering if Jay or some
4 capitated health plan could give you the data for their
5 Medicare caseload, numbers of tests and types of tests, the
6 distribution that you could -- where you have the incentives
7 aligned for optimal use of inputs like tests. And you could
8 compare it then to what's going on in the fee-for-service
9 system.

10 MR. HACKBARTH: Jay, can you bring that to the
11 next meeting?

12 DR. CROSSON: Yes, I can have it tomorrow.

13 In all seriousness the answer is yes, we can do
14 that.

15 DR. NELSON: To respond to Bob, in many instances
16 the physician ordering the test doesn't get any kind of
17 benefit at all. It's a commercial laboratory that does it
18 or at the most they get a drawing fee.

19 DR. REISCHAUER: I'm not pretending there's
20 necessarily a financial motive behind this. What we're
21 talking about is really quality of care and efficient
22 provision of care. That's all.

1 DR. NELSON: And to some degree, you may find
2 increased utilization in Jay's shop because they're paying
3 more attention to following the guidelines.

4 DR. REISCHAUER: I'm agnostic on what we find.

5 MR. HACKBARTH: Even if the physician, as you
6 correctly point out, is often not benefitting directly from
7 the increased utilization there still might be a different
8 attitude towards testing for a physician that works within a
9 constrained system and they know that they're working within
10 a defined budget.

11 So in neither case are they getting direct
12 financial benefit but one knows that hey, we've got to live
13 within a budget and the other is working in an open-ended
14 fee-for-service system.

15 DR. REISCHAUER: And one is bearing the liability
16 costs themselves and the other a corporation is doing it for
17 them. So there's a lot of reasons.

18 DR. CROSSON: I just had a simple question about
19 the second slide. 38 percent of the labs are not physician
20 labs, hospital labs or independent labs. So what are they?

21 And then to what extent -- what is the volume
22 there? Is that 38 percent of the labs but a small fraction

1 of the volume?

2 MS. KELLEY: Yes, that's exactly right. The labs
3 in the other category run the gamut from home health
4 agencies, SNFs, nursing homes, dialysis facilities.
5 Obviously, these facilities perform a lot of lab services
6 but many of the services that they provide are covered under
7 other payment systems.

8 In terms of the Part B clinical lab fee schedule,
9 a very small proportion of those labs are paid under the fee
10 schedule.

11 One of the things we're having a little difficulty
12 sorting out right now is the volume of services provided by
13 physician office labs versus independent labs for Medicare,
14 but we do know from some other data that's dated if you will
15 that physician office labs provide a pretty small proportion
16 of the total.

17 I don't know if that answers your question.

18 DR. CROSSON: Can I just make one other point?
19 Going back to that list of tests, to get to the issue of
20 value or efficiency, one of the things I don't see on there,
21 for example, as a clinician are useful but much simpler and
22 less expensive tests that substitute, in many cases, for

1 some of these. For example, hematocrit instead of a
2 complete CBC or a serum sodium and potassium as opposed to a
3 complex metabolic panel.

4 There are some issues, and I don't know all the
5 issues that go into choosing those. But I was sort of
6 surprised when I looked at it to see the absence of some
7 simpler test which are less costly.

8 MR. WINTER: It could be there are incentives in
9 the payment system to bill for the more bundled panel of
10 tests than the simple individual tests. And that might
11 explain why you're seeing the more comprehensive bundle of
12 tests.

13 DR. NELSON: For the sake of completeness, it
14 would be helpful to include some comments about proficiency
15 testing, particularly for physician office laboratories,
16 including instances in which it's not required for
17 certification but in which the physician nonetheless wants
18 proficiency testing to assure accuracy.

19 CMS has some data on that and ACP has some data on
20 it.

21 MS. DePARLE: I spoke with Ariel about this after
22 our first discussion of this a couple of months ago but I

1 had understood from people at JCAHO and from some others
2 that there are some real issues with a shortage of lab
3 technologists, technicians and in particular, in some states
4 where there may be higher standards, more requirements for
5 staffing and oversight and in some facilities where there
6 are more complex tests being done that require, I'm told, a
7 higher level of certification, that that is affecting labs
8 and causing them problems and quality issues, et cetera.

9 I know you haven't yet drafted a chapter but I'd
10 be interested in knowing if you know anything about that yet
11 and if we'll be able to assess that?

12 MS. KELLEY: We've read reports of that, also. At
13 this point we don't have any data necessarily backing that
14 up, but we've heard similar reports. We're looking forward
15 to GAO's report because they were looking particularly into
16 the accreditation issue.

17 Right now labs have the choice when they apply to
18 CMS for certification. If they're performing the moderate
19 and higher complexity tests they choose whether they want to
20 be surveyed by state surveyors or by a private agency like
21 JCAHO.

22 One of the things that GAO is looking into is how

1 that process works and whether or not the accreditation
2 across the board is covering all the bases. So I think that
3 will get to some of your issues.

4 MR. WINTER: We're in the process of setting up a
5 meeting with JCAHO to find out how their accreditation
6 process works for labs, what kinds of problems they've been
7 encountering and how they're dealing with that.

8 DR. NELSON: Talk to COLA, too. COLA certifies
9 more office labs than the Joint Commission.

10 MR. HACKBARTH: Thank you very much.

11 We are now finished with the presentations for
12 today, well ahead of schedule. So the first order of
13 business will be to have our public comment period, but I'd
14 like to ask the commissioners if they can stay for a few
15 minutes after we're finished. I'm looking at the scheduled
16 for tomorrow and thinking about the snow and I think it
17 might be helpful if we could have a brief conversation after
18 the meeting and that may allow us to get out of here quicker
19 tomorrow. So please stay after the meeting.

20 And now we'll go to the public comments, with all
21 of the usual ground rules about brevity and no repetition
22 and all of that stuff.

1 MR. MERTZ: I can't repeat anybody because I'm
2 first.

3 I'm Alan Mertz. I'm President of the American
4 Clinical Laboratory Association.

5 I want to thank you for focusing on labs and
6 appreciate the presentation that was given. We appreciate
7 the rigor in which they're looking at labs. We welcome
8 that.

9 Clearly, we've had problems with policymakers not
10 completely recognizing the value of laboratory services.
11 Just a couple of facts to keep in mind. For the last 20
12 years labs have been reduced by 40 percent in real terms
13 under Medicare. The fee schedule has not been updated fully
14 for inflation but twice in the last 15 years. It's frozen
15 until 2008. We've compared us to all the other parts of
16 Part B Medicare and we have lagged behind all of those other
17 factors.

18 I did want to comment on Mr. Durenberger's comment
19 about maybe the labs are maybe billing for services not
20 performed. It's actually the other way around. When we're
21 sent a test, we perform it that very night. Somewhere
22 between 5 and 10 percent of the time we're not paid. And

1 for some tests, we're paid very, very low compared to third
2 parties. Particularly in new technologies we're underpaid.

3 Laboratory spending is only 1.6 percent of
4 Medicare spending. It's a tiny part of the budget but it
5 has a huge impact on patients' lives and other Medicare
6 spending. But while we're only 1.6 percent of Medicare
7 spending, we make up 60 percent, 60 percent, of the
8 individuals' medical record. And laboratory spending
9 influences 60 to 70 percent of all clinical decision making.

10 We think we need to look at laboratory spending in
11 this light, in a new light. It's not so much what is the
12 cost of a lab test but rather what is the benefit of labs to
13 the program and to the patient's health? When we think
14 about our own experiences and those of our loved ones, I
15 think this comes to life. I'll just give you an example and
16 then I'll conclude.

17 I have a close friend. She just entered Medicare
18 at 65. She had her first glucose and cholesterol tests in
19 many years. These tests cost \$11.54. Based on that her
20 doctor diagnosed that she has adult onset diabetes, high
21 cholesterol. And as a result, she's changed her diet, she's
22 increased her exercise. She's gone on statins. She's now

1 significantly lowered her risk of going on in diabetes, its
2 associated complications, heart attack and stroke.

3 When you consider the \$11.54 cost of these tests
4 compared to the tens of thousands of dollars that will be
5 saved in her care, I think this is really how we should try
6 to look at this.

7 There are many more examples of this that I won't
8 go into.

9 Again, we welcome the dialogue we're having with
10 MedPAC. I could have answered all the questions that you
11 posed a few minutes ago. So we welcome the dialogue with
12 Ariel and the staff because I think we can help them.

13 But we're confident that if you look at labs in
14 this new way and looking at the value of labs and not in a
15 silo, that MedPAC will embrace the notion that lab services
16 add value, they save lives and they save money.

17 Thank you.

18 MR. HUNTER: Mr. Chairman, members of the
19 Commission, Executive Director Miller, MedPAC staff, my name
20 is Justin Hunter. I am Vice President of Government and
21 Regulatory Affairs for HealthSouth.

22 I know that there was some discussion earlier

1 today about some of our cost reporting data. The short of
2 it is this. We've been working on it, we're working on it
3 and we will continue to work on it. We have disclosed as
4 much as has been asked of us by staff, MedPAC staff, and we
5 continue to work through our cost report data.

6 That has been the result of a number of activities
7 that occurred several years ago under prior management and
8 leadership of the company.

9 I want to touch upon a couple of points that were
10 discussed today during the IRF presentation. First and
11 foremost, I want to underscore our very strong agreement
12 with the notion that the right kinds of patients ought to be
13 treated in inpatient rehabilitation hospitals. We embrace
14 that.

15 Currently and historically there are at least
16 three mechanisms that I can think of that are designed to
17 ensure as best they can be ensured that the right kinds of
18 patients are treated in rehab hospitals, the first of which
19 is something known as the HCFA Ruling 85-2. It's a set of
20 eight criteria that were issued by CMS back in 1985 and they
21 have been the gold standard for determining the medical
22 necessity and appropriateness of inpatient rehabilitation

1 and whether a patient instead could be treated elsewhere,
2 such as in a SNF or home health.

3 Secondly, there are the local coverage
4 determinations developed by various fiscal intermediaries.

5 75 percent of our claims happen to go through one fiscal
6 intermediary and that fiscal intermediary has developed an
7 LCD for inpatient rehabilitation. We live by it as best we
8 can.

9 Thirdly, there are fiscal intermediary claims
10 review activities. And when I'm not at MedPAC and
11 elsewhere, I find myself on the phone oftentimes dealing
12 with claim denials that are issued by our FI.

13 In the long run, however, and in the longer term,
14 there was mention of patient assessment instrument. That's
15 been discussed here before. We welcome that. We welcome
16 the development of a patient assessment instrument. We
17 welcome the development of integration in the post-acute
18 setting. We think that long-term post-acute care ought to
19 focus less on the sign above the door and more on the needs
20 of the patients, their outcomes and their performance of
21 providers.

22 So the 75 percent rule. I think there was a lot

1 of discussion about that today, in terms of the uncertainty
2 that it has created. And indeed it has created a great deal
3 of uncertainty in this space.

4 There were several percentages that were offered
5 in terms of caseload decline and volume decline. I think
6 it's important for each of you to take into account that
7 this volume decline represents a material underestimation on
8 the part of CMS when it implemented this policy. In fact,
9 they recently acknowledged it in a memorandum that they
10 issued last week on the 75 percent rule.

11 My point here is there is, in fact, a lot of
12 uncertainty about the 75 percent rule now and going forward.
13 In that regard we are greatly appreciative to MedPAC for
14 taking into account the effects of the 75 percent rule as it
15 relates to your work on payment adequacy.

16 Lastly and very quickly, Chairman Hackbarth, you
17 mentioned LTCH criteria. We don't occupy a great deal of
18 space in the LTCH world but we do occupy some. We strongly
19 believe that we need to move away from the current standard
20 basically of the 25-day average length of stay and begin to
21 look at real criteria aimed at determining who is best
22 appropriate for an LTCH level of care.

1 HealthSouth stands ready to work with MedPAC, with
2 Congress, and with CMS to achieve these kinds of objectives.
3 We certainly appreciate the opportunity to have the dialogue
4 here today, the dialogue that we've had on an ongoing basis
5 with the staff.

6 I thank each of you for your time.

7 MS. ZOLLAR: My name is Carolyn Zollar. I'm Vice
8 President of Government Affairs and Policy Development for
9 the American Medical Rehab Providers Association and I'll
10 give you a few dittos to what Justin just said, but I have a
11 few other comments.

12 I appreciate the care that's been taken in the
13 analysis the staff presented to you today. I would note for
14 the comment that was raised earlier that one reason that the
15 average difference between payments and costs pre-PPS is
16 there's a TEFRA limit that limited total payments to the
17 facilities. I don't know if that was mentioned. In
18 addition to Sally's point that the complexity of care and
19 the cost of that complexity of care and payment based on
20 costs was also not recognized under TEFRA and was one of the
21 driving forces in the structure of the PPS.

22 We also believe the decline in volume has serious

1 cost implications and impacts on margins, which you saw
2 today in the analysis, and which we raised in the letter to
3 you. We will continue to work with the staff on additional
4 analyses and in the future on the issues that were raised
5 about potentially looking at the structure of the PPS, which
6 is a whole separate issue, and on the larger issue of
7 integration of post-acute care, be it data assessment tools
8 or payment systems, which will be the next letter.

9 Again, we appreciate your continued concern as our
10 industry is going through a very, very volatile time as the
11 data showed today.

12 Thank you for your attention to this issue.

13 MR. CHIANCHIANO: Good afternoon. I'm Dolph
14 Chianchiano, Vice President for Health Policy at the
15 National Kidney Foundation.

16 We appreciate the Commission's concern about
17 malnutrition among dialysis patients. Malnutrition puts
18 dialysis patients at increased risk for hospitalization,
19 which in turn has implications for the Medicare program, but
20 also increased risk for mortality.

21 I'd like to make some footnote-type comments with
22 regard to that issue. First of all, this phenomenon may be

1 the flip side of the productivity phenomenon that we have
2 noted in the dialysis industry. The typical nutritionist in
3 a dialysis facility has a caseload of at least 150 patients.
4 Some have caseloads up to 200 patients. With those
5 caseloads and with the complex metabolic problems that these
6 patients encounter, it is difficult to provide the kind of
7 services that would help resolve the malnutrition issues.

8 Furthermore, Medicare does not provide payment for
9 nutritional supplements. In addition, Medicare does not
10 allow dialysis providers to give or supply nutritional
11 supplements free of charge to indigent patients. And that,
12 I submit, is an issue that the Commission might want to
13 consider.

14 Finally, the National Kidney Foundation, in its
15 clinical practice guideline development program, has a
16 specific guideline on nutrition for kidney patients. I'd be
17 glad to share that information with you.

18 Thank you.

19 MR. CALMAN: Good afternoon. My name is Ed
20 Calman. I'm General Counsel the National Association of
21 Long-Term Care hospitals.

22 I'd like to make two brief points concerning the

1 recommendation for update factor and then tell you about two
2 matters that our association is undertaking which you should
3 find of interest.

4 First of all, this year CMS regulations provide
5 for a one-time adjustment to the standard amount to account
6 for approved coding. A regulation was adopted when the PPS
7 was adopted. It's 42 CFR 412.523(d)(3).

8 This is a customary and usual adjustment that's
9 made to new PPS systems. When this adjustment was made to
10 the IPPS system, the standard amount went down. When it was
11 made to the IRF system a year ago, the standard amount went
12 down. And I suspect that the standard amount will go down
13 with long-term care hospitals. This rule is currently under
14 development and will be proposed, we are told, either in
15 January or February.

16 So I think in arriving at your final
17 recommendation you should consider the effect of this one-
18 time adjustment of the standard amount on the long-term care
19 hospital industry.

20 Secondly, I want underscore I think this is a very
21 important matter. The profit margins that were shown were
22 measures of central tendency. There are long-term care

1 hospitals that have poor to mediocre margins. And those are
2 the hospitals that serve the medically indigent.

3 You can pick most of them out from the data
4 because you can look at the Medicaid days off the cost
5 report.

6 I think it's appropriate to assess the effect of a
7 zero update factor on those hospitals. It's more difficult
8 to affect the assess of a zero update factor on charity
9 care. That's a very important matter for long-term care
10 hospitals because the indigents that access long-term care
11 hospitals are crossover cases. They enter with Medicare
12 Part A, they're very ill, they exhaust Part A and they cross
13 over. And many states in this country have very meager
14 Medicare day coverage. In Texas it's 30 days, in
15 Mississippi it's 30 days and in Alabama's it's three.

16 There's a number of long-term care hospitals in
17 those states that serve those patients and they need margins
18 to serve those patients from the Medicare program because
19 there's no DSH adjustment to long-term care hospital PPS.

20 I think that, in addition to assessing the
21 question of serving the medically indigent, that there
22 should also be an assessment of the effect of a zero update

1 factor on urban and rural differences and the effect it will
2 have on access to care in those locales.

3 Moving on, I would like to tell you some of the
4 activities that we're involved in which I think go to
5 addressing more long-term issues. I was going to say long-
6 term care issues, but it's long-term structural policy
7 issues.

8 We have developed outcome criteria. We have
9 finished the first multiple site, 23 site ventilator weaning
10 study in long-term care hospitals showing outcome data,
11 costs, functional status on admission, discharge and 12
12 month after discharge.

13 We are also moving forward with a database so we
14 can assess outcome measures on patients and we have
15 developed clinical criteria to determine the appropriateness
16 of admission continued stay and discharge to long-term care
17 hospitals, and we're currently engaged in a professional
18 validation of those criteria.

19 So we are certainly trying to be part of the
20 solution in this area. We welcome integration of payment
21 systems. But we certainly hope that along the way that the
22 providers that are serving especially the medically indigent

1 are not disadvantaged.

2 So I thank you very much for your consideration of
3 those factors.

4 MR. WATERS: Good afternoon. My name is Bob
5 Waters and I would like to make a few brief remarks on
6 behalf of the American Association of Bioanalysts, AAB. Our
7 organization represents the owners, the directors, the
8 supervisors and technologists of community clinical
9 laboratories.

10 Advances in clinical laboratory testing are
11 responsible for detecting and diagnosing diseases faster and
12 more accurately than ever before, allowing doctors to
13 prescribe more effective and often less invasive treatment
14 options. In fact, laboratory tests play a leading role in
15 more than 70 percent of all medical decisions.

16 Despite the importance of laboratory testing,
17 patient access to laboratory tests is threatened by
18 inadequate reimbursement. Over the past two decades
19 reimbursement for laboratory testing has been cut by 45
20 percent. Since 1990 the full CPI update for clinical
21 laboratory fee schedule has only been applied four times.

22 Moreover, the laboratory industry has absorbed 15

1 percent of the provider cuts in the Medicare Modernization
2 Act of 2003, which included a continued CPI freeze through
3 2008.

4 In addition, the specimen collection fee paid to
5 laboratories establishment in 20 years ago at \$3 has never
6 ever been increased, even for inflation. The current cost
7 of specimen collection ranges from \$6 to \$9 due to normal
8 price inflation as well as updated blood borne pathogen
9 regulations and new Sharps systems requirements. It has
10 become incredibly more expensive to collect those specimens
11 and that cost is borne by the community clinical
12 laboratories.

13 During this time period of frozen payments for
14 clinical laboratories services and specimen collection, the
15 independent laboratory sector has become ever more
16 concentrated. I know that was noted in some of the
17 materials that were presented to you earlier today. If
18 reimbursement levels remain flat, coupled with the
19 introduction of new pricing models for laboratory services
20 that have not been adequately tested, independent community
21 laboratories could easily disappear from the market.

22 Policymakers must ensure that new policies such as

1 competitive bidding live up to their names and truly create
2 more competition rather than less competition, that they
3 don't further ensure that only a few laboratories dominate
4 the entire market. I think any economist who would look
5 closely at the independent laboratory sector would recognize
6 that this is a significant issue in this field. Only with
7 the diversity of laboratory services can our health system
8 hope to serve all segments of the Medicare patient
9 population, including those living in rural areas and those
10 that are in nursing homes.

11 Diversity of laboratory services is also crucial
12 during natural disasters and bioterrorism events. These
13 events have the capacity to disrupt our air transportation
14 system, leaving our local laboratories sometimes as our only
15 and last line of defense.

16 As MedPAC examines the laboratory industry, AAB
17 urges the commissioners and their staff to undertake a
18 comprehensive and accurate review of the entire independent
19 laboratory market, as well as the entire laboratory market,
20 and look at the essential and vital services that are
21 provided to the local communities.

22 Thank you very much.

1 MR. HACKBARTH: Okay, thank you.

2 So if the people in the audience would bid us
3 adieu and we'll see you tomorrow and the commissioners will
4 stay, we'd appreciate that.

5 [Whereupon, at 4:59 p.m., the meeting was
6 adjourned, to reconvene at 9:30 a.m. on Friday, December 9,
7 2005.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Friday, December 9, 2005
9:33 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

1

P R O C E E D I N G S

2

MR. HACKBARTH: Okay, good morning.

3

We have two presentations scheduled for today, one
4 on valuing physician services and the other on assessment of
5 payment adequacy. There will be draft recommendations to
6 discuss on the both of these. The final votes, of course,
7 do not occur until January.

8

Kevin, are you going to lead the way on the first
9 item?

10

DR. HAYES: Yes.

11

Our topic here is valuing services in the
12 physician fee schedule. This is a topic that you considered
13 in September and again in November. We're here today to
14 briefly recap points made previously and to present some
15 draft recommendations.

16

Before we begin, I would like to just take a few
17 moments to address points made by Dr. William Rich during
18 the public comment period at the November meeting. Dr. Rich
19 is the Chairman of the Relative Value Scale Update Committee
20 or RUC. Because some of our draft recommendations involve
21 the work of the RUC, Glenn asked staff to review the points
22 made by Dr. Rich and to offer some possible responses.

1 The first point that Dr. Rich made concerned
2 valuation of evaluation and management services. The point
3 here was that an argument can be made that not enough
4 revenue has shifted toward E&M services over the course of
5 experience with the physician fee schedule, but that
6 valuation of E&M services is not the reason for this.
7 Instead, it's growth in the volume of other services,
8 particularly imaging and tests.

9 A way to respond to a point like this would be to
10 say there is much agreement between this point and work of
11 the Commission. Recall, in particular, at the April meeting
12 researchers from the Urban Institute presented work on
13 changes in the volume of physician services and changes in
14 the valuation of those services and showed that over the
15 course of the fee schedule E&M services appear to be losing
16 ground in terms of total volume of services received by
17 Medicare beneficiaries. At the same time, the valuation of
18 those services has gone up.

19 So there's some agreement with the point made by
20 Dr. Rich.

21 The other way to respond on this matter would be
22 to note that in the draft recommendations that we're going

1 to present in just a few minutes that for the most part they
2 concern not the valuation of E&M services but focus more so
3 on services in the fee schedule that may be overvalued. The
4 concern here is that overvalued services could be too
5 profitable, could be creating some financial incentives for
6 unnecessary use of those services.

7 Another point made by Dr. Rich concerned the fact
8 that the RUC is an expert panel and not necessarily a
9 consensus or representative panel. As you'll see, the draft
10 recommendations recognize that CMS has the option to use the
11 RUC as a source of advice and has chosen to do so.

12 The question before the Commission is whether it's
13 possible to make some recommendations to try and improve
14 upon the process for review of RVUs.

15 On the specific point of whether the RUC is a
16 representative panel, as you know the Commission has
17 received letters on this point. Staff has met with
18 physicians who have viewpoints on the matter. As near as we
19 can tell there's kind of two opposing viewpoints on this.
20 On the one hand, we have the perspective that the RUC is an
21 expert panel, that physicians that serve on the RUC put
22 aside the interests of their specialties whenever they do

1 their work. The figure of speech that's used here is that
2 RUC members put on their RUC hat when they perform their
3 duties.

4 On the other side we have the perspective of those
5 who feel that the physicians who perform evaluation and
6 management services are not adequately represented on the
7 RUC, that these are very important services, and that the
8 problem here is that E&M services account for a very large
9 share of spending in the fee schedule, and that any change
10 in the valuation of those services can have very profound
11 impacts on payments for other services.

12 The perspective there is we need adequate
13 representation of those interests on the RUC in order to
14 ensure adequate valuation of those surfaces.

15 The final point here concerns the mechanism for
16 identifying overvalued services. Here again we see quite a
17 bit of a agreement between what the Commission has been
18 considering and Dr. Rich's point, which is that there does
19 need to be a mechanism outside of the RUC, probably at CMS,
20 for identifying overvalued services.

21 The other point that Dr. Rich made, and I think
22 there would be some agreement on this as well, is that CMS

1 staff are overworked and that perhaps there is a need for
2 the Congress to consider some change in responsibilities and
3 some steps toward ensuring adequate resources for CMS.

4 So that's our attempt here to try and address
5 those points that were made at the November meeting.

6 We now want to move on to the core of our
7 presentation here today. Dana is going to first recap some
8 points that we've made previously on these matters.

9 MS. KELLEY: As you know, we've been presenting
10 information about this issue to you over the past few months
11 and we discussed that making sure services are adequately
12 valued is important in order for Medicare to be a prudent
13 purchaser.

14 Misvaluation means that Medicare is paying too
15 much for some services and too little for others. As a
16 result the market for physician services can become
17 distorted with physician decisions influenced by financial
18 considerations rather than solely by clinical necessity.
19 That can increase or decrease volume inappropriately.

20 Over time, as some Commissioners have pointed out,
21 misvaluation can make certain specialties more financially
22 attractive than others, which has implications for the

1 supply of positions.

2 As you know, the Medicare physician fee schedule
3 was implemented largely to address what was widely perceived
4 as misvaluation in the old charge-based method of payment.

5 As expected, under the resource-based payment method,

6 payment rates for evaluation and management services

7 increased relative to other services such as surgery and

8 procedural services.

9 But there are signs that misvaluation of physician
10 services continues to be a problem. Aggregate payment for
11 certain types of services has grown at widely disparate
12 rates with growth in payments for imaging and minor
13 procedures outpacing that of visits and major procedures.

14 Consequently, as you can see here, payments for E&M services
15 declined as a share of total payments between 2002 and 2004,
16 as did payments for major procedures. This is largely due
17 to differences in volume growth across services.

18 But the Commission has voiced concerns that
19 differences in the profitability of services is partly
20 responsible for the differential volume growth.

21 The results of CMS's reviews of the physician work
22 relative values and the fee schedule provide another

1 indication that misvaluation is an issue. CMS is required
2 by law to review and, if necessary, refine the fee schedules
3 relative values at least every five years. CMS completes
4 its five-year review with substantial help from the RVS
5 Update Committee, or RUC, which as you know is a panel
6 convened by the AMA and physician specialty societies.

7 As you can see here, during the first two five-
8 year reviews, completed in 1996 and 2001, the RUC
9 recommended many more increases than decreases in the
10 relative values of services. The reviews yielded those
11 results even though the factors that can lead to a service
12 becoming misvalued suggest that services may be more likely
13 to become overvalued over time than undervalued. The vast
14 majority of these recommendations were accepted by CMS. In
15 both the first and second five-year reviews, the growth in
16 the RVUs for so many codes would have increased total
17 payments so CMS was required to reduce payments for all
18 services to maintain budget neutrality.

19 Over the past few months we've discussed several
20 reasons why misvaluation of services persist, focusing on
21 the role of CMS and the RUC in the five-year review process.
22 It appears that throughout this process CMS relies too

1 heavily on physician specialty societies to identify
2 services that merit review and to provide evidence in
3 support of increasing or decreasing the relative values of
4 services under review. The result is that the process does
5 not do a good job of identifying and correcting overvalued
6 services.

7 Today Kevin, Carol and I have five draft
8 recommendations for you to consider which should help
9 improve the five-year review process.

10 DR. HAYES: Before we get to that first
11 recommendation, let me just provide a couple of slides here
12 to set the issue up. It concerns the specialties
13 represented on the RUC.

14 What we're after here is to consider really the
15 composition of the RUC and which types of physicians are
16 represented there. Our goal here is to try and respond to a
17 point made at the November meeting that perhaps it is time
18 to move away from a Senate model for the RUC.

19 Today, we see that there are 23 different
20 specialties represented on the panel. Those seats are
21 fairly evenly divided between medical and surgical
22 specialties. A concern would be that this composition is

1 not necessarily representative of the types of services that
2 physicians furnish to Medicare beneficiaries.

3 There are different ways to look at this issue of
4 representation. One is shown here on this slide, which
5 compares spending by type of service with the specialties on
6 the RUC. What we see here is that evaluation and management
7 services account for about 42 percent of spending under the
8 physician fee schedule. But then when we look at the
9 composition of the RUC, we see that only about 30 percent of
10 the specialties represented there derive a majority of their
11 Medicare revenues from E&M services.

12 There are other ways to look at this issue. For
13 example, if one wanted to take the perspective that we view
14 primary care physicians, let's say, as an important group of
15 physicians furnishing services to Medicare beneficiaries in
16 terms of serving as a first point of contact in the health
17 care system -- continuing care, chronic care, chronic care,
18 all of that -- that we would see here that we have three
19 specialties representing primary care: family practice,
20 internal medicine, pediatrics. Yet those same specialties
21 account for -- and those therefore are about 13 percent of
22 RUC membership. Those specialties account for 20 percent of

1 spending the fee schedule and they account for about 23
2 percent of the beneficiaries seen by physicians billing the
3 program.

4 There are a number of different dimensions to this
5 issue of representation. What we could say is that given
6 those different dimensions, it's wise for the medical
7 community to step up here and offer some perspective. It's
8 clearly the kind of a situation where we have a moving
9 target and it's not clear exactly what to do, but some input
10 from the medical community would be very helpful.

11 We are now ready to look at the draft
12 recommendation that we drafted here which reads as follows:
13 In establishing and reviewing relative value units the
14 Secretary should receive advice from physicians who are
15 representative of the specialties that most often produce
16 services to Medicare beneficiaries.

17 We have considered the implications of this, both
18 from the standpoint of spending and beneficiaries and
19 providers. On the spending side, the relative value units
20 and the fee schedule, any changes in them are, by law,
21 implemented in a budget neutral manner. So we do not
22 anticipate spending applications associated with this

1 recommendation.

2 There may be some redistribution of payments, but
3 we do not anticipate large impacts for Medicare
4 beneficiaries. There may be some redistributive effects
5 from a provider payment standpoint however.

6 I should point out, by the way, that this profile
7 of implications for spending, beneficiaries, providers, that
8 applies for all recommendations that we'll go over today.

9 That's this recommendation and we're ready to move
10 on to the next one. Carol will present that.

11 DR. CARTER: Given the tendency of the current
12 process to identify undervalued services and to recommend
13 increases in RVUs, it is important that CMS play a lead role
14 in identifying misvalued services and revising relative
15 values when appropriate. Yet we recognize that CMS has
16 limited resources.

17 Our second recommendation considers one way for
18 CMS to effectively address biases of the current valuation
19 process. It reads: the Secretary should establish a group
20 of experts to advise CMS throughout its process of reviewing
21 work RVUs. This group should include carrier medical
22 directors and experts in economics, technology diffusion,

1 and physician payment from the private sector.

2 Currently CMS uses ad hoc refinement panels to
3 help it assess large differences between valuations it has
4 proposed and public comments it receives. The panels
5 include carrier medical directors and physicians.

6 Building on this idea, we propose that CMS
7 establish a group of experts that would assist it in other
8 areas of the review process. The group could include
9 representatives from medical specialties, carrier medical
10 directors and experts in the fields that I mentioned.

11 Experts in medical economics will help CMS decide how to
12 adjust RVUs to account for any economies of scale that
13 accompany volume growth. Experts in technology diffusion
14 would help CMS evaluate the efficiencies of learning by
15 doing associated with new services.

16 Private payers would provide information about
17 distortions in payment rates gathered from the markets that
18 they operate in.

19 To ensure that the panel has the medical expertise
20 required to consider the wide array of services the
21 membership could have a core set of experts and a varying
22 set of clinical experts tailored to the specific services

1 under review.

2 We envision the group being involved at two key
3 points in the RVU process. First, it could review the codes
4 that CMS's data analysis have identified as potentially
5 misvalued and make recommendations to CMS about which
6 services should be forwarded to the RUC for further
7 consideration. Second, once the RUC's recommendations are
8 submitted back to CMS for consideration the group could
9 assist CMS in reviewing the evidence, arguments and service
10 valuations. Its assistance would help counter any biases in
11 the RUC recommendations and may reduce the public comments
12 it receives on the valuations of services.

13 The next recommendation would help CMS improve the
14 identification of misvalued services. Currently the vast
15 majority of services that are reviewed during the five-year
16 review process are identified by physician specialty
17 societies and are likely to be perceived as undervalued
18 rather than overvalued.

19 It's important, therefore, for CMS to identify
20 codes that may be overvalued and submit them to the RUC for
21 review along with supporting evidence. Analyses of Medicare
22 data such as changes in length of stay, site of service,

1 volume, and practice expense could provide crucial
2 information to support agency claims that services are
3 overvalued.

4 The draft recommendation is that the Secretary
5 should institute automatic reviews of services that have
6 experienced substantial changes in length of stay, site of
7 service, volume, practice expense, and other factors that
8 may indicate changes in physician work.

9 The recommended expert panel that Carol spoke of
10 could assist CMS by reviewing the codes identified through
11 data analyses and consider which services warrant further
12 consideration by the RUC. The panel could also help CMS in
13 developing additional evidence providing support for
14 correcting misvalued services.

15 The fourth proposed recommendation would help
16 ensure accurate payment for recently introduced services by
17 instituting automatic reductions in work relative values
18 after a specified period of time. This would reflect the
19 fact that we expect the work involved in furnishing many new
20 services will decline over time as physicians gain
21 familiarity with it and become more efficient.

22 The draft recommendation reads that the Secretary

1 should automatically reduce the work relative values for
2 recently introduced services after a specified period of
3 time.

4 New services would be scheduled for reductions
5 after a period of time such as three years or could be
6 reduced gradually over a somewhat longer period. The
7 Commission would specify that CMS should conduct research to
8 determine if there's a typical trajectory to the decline in
9 work that occurs in the early years after a service is first
10 introduced.

11 MedPAC would also indicate that specialty
12 societies and other interested parties should be given an
13 opportunity to submit evidence supporting a specific RVU for
14 a service scheduled for automatic reduction. In the absence
15 of compelling evidence, however, reductions would be
16 implemented.

17 CMS should also consider if services related to
18 the new service in question should also be reviewed and
19 revised.

20 DR. CARTER: Although the majority of services
21 furnished to beneficiaries has been reviewed and we're
22 proposing ways that CMS could improve the way it identifies

1 services that warrant examination, our last recommendations
2 considers those services that otherwise would not get
3 reviewed.

4 It reads to ensure the validity of the physician
5 fee schedule the Secretary should establish a process by
6 which all services are reviewed periodically.

7 Since the work RVUs were established more than 15
8 years ago about one-sixth of the work RVU volume has not
9 been reviewed and the relative values may no longer reflect
10 current medical practice. This recommendation would require
11 that CMS consider every service periodically so that the fee
12 schedule is kept as accurate as possible.

13 Because this volume is spread over so many codes,
14 about 50 percent of the individual services under the fee
15 schedule, we recognize that it is not feasible for CMS to
16 take a review of this scale. One way to accomplish this
17 would be for CMS, on an annual basis, to select a subset of
18 codes from those that have not yet been reviewed and have a
19 group of experts examine the current valuations. Services
20 that appear to warrant further review could be forwarded to
21 the RUC. The RUC, in turn, would use its regular process to
22 review the services and make recommendations to CMS.

1 The Secretary should choose a strategy that best
2 fits the agency's resource constraints.

3 We acknowledge that some services that have not
4 been reviewed have very low volume and that using the
5 valuable RUC and CMS resources to validate their work RVUs
6 is not sensible. To consider the RVUs for very low volume
7 services, CMS may want to indicate to the expert group
8 whether more recent reviews of services with similar
9 components or services that are somewhat similar, what those
10 reviews have done to the RVUs.

11 We also recognize that this recommendation places
12 additional burdens on the RUC and on CMS and that both may
13 require additional resources to implement this
14 recommendation. But we note that some process is required
15 to ensure that services that otherwise would not get flagged
16 are periodically considered so that the work relative values
17 are kept as accurate as possible.

18 This ends our presentation and we can answer any
19 questions that you have.

20 MR. HACKBARTH: This has been a very helpful
21 process for me over the last several sessions. I've learned
22 a lot about the RUC that I didn't know before and that's

1 good. I think we've had a good exchange with people who
2 have been involved, and both through Bill Rich's oral
3 statements here and letters that we've gotten from him and
4 many of the specialty societies.

5 As a result of that, I guess I am more comfortable
6 today than I was at the beginning of the process that what
7 happens within the RUC is analytical as opposed to
8 political. Being the cynic that I am, I'm not out 100
9 percent confident that there's no politics involved,
10 specialty politics involved, but I feel better about the
11 process than I did when I knew less about it.

12 It still seems to me that we have, even if you
13 stipulate that it's principally an analytic process within
14 the RUC, we still have very large problems about what issues
15 come before the RUC. I feel even more strongly about that
16 concern than I did at the beginning of the process.

17 I think one of the problems that we have is that
18 under the current structure I guess it's left to CMS to
19 drive what comes before the RUC and make sure that they're
20 looking at potentially overvalued codes. But CMS is
21 chronically short of resources. This is one of the things
22 that apparently seems to fall off the plate on a regular

1 basis with severe consequences, really significant problems.

2 We have a series of recommendations. I think two
3 through five, in various ways, try to address that what gets
4 on the plate issue. And I feel very good about that. I
5 think that's quite urgent to do.

6 Recommendation one addresses the internal dynamics
7 of the RUC, tries to address them through altering the
8 representation which, all things considered, I think might
9 be a good thing to do, although I'm less confident that
10 that's dramatically going to alter the output of the RUC,
11 changing a few seats, shifting the balance between
12 specialties. It's less clear to me that that's going to
13 have a dramatic affect on the ultimate outcome.

14 So that's sort of my take on this journey that
15 we've been on in the last few months. From there let me
16 open it up to other questions or comments.

17 MR. MULLER: Glenn, I share your comments and
18 commend the staff for doing this work and edifying all of
19 us.

20 Let me just talk to the relationship between
21 recommendation three and four and whether you consider --
22 maybe go to four first -- making four one of the triggers

1 under three. So for example, rather than saying
2 automatically reduced, you could have the newly introduced
3 services be one of the criteria under three for services
4 that get reviewed. I'm sure you considered that.

5 Could you talk just a little bit about why you
6 went this way, rather than making it one of the triggers
7 under three?

8 DR. HAYES: The thought was that under
9 recommendation four there is pretty compelling evidence that
10 work RVUs would go down with newly introduced services. We
11 cited in the draft chapter some work done by a HCFA
12 contractor and they ticked off a list of reasons why they
13 would think that work RVUs would change, having to do with
14 learning by doing and so on.

15 So we thought that that was compelling enough
16 evidence to support the idea that we would expect RVUs to go
17 down for newly introduced services after a period of time.
18 That was pretty much it.

19 MR. MULLER: Is there any kind of distribution on
20 that where some -- I would assume that some services, in
21 fact, seem to be undervalued when they first started. It
22 may not be a bell curve so it may be fairly skewed. But I

1 assume that some services, in that sense, are undervalued.

2 So I wouldn't assume it's 100 percent of services
3 that basically, as you say, become less work over time. If
4 you follow me.

5 So my suggestion is you consider -- if that is the
6 case, again it may not have to be a bell curve in terms of
7 ones that become easier over time versus harder over time.
8 But you may want to consider this as one of the triggers
9 under three.

10 DR. MILLER: [off microphone] By triggered, you
11 mean something that was --

12 MR. MULLER: Could you do three, please?

13 In terms of -- just make that instead of site of
14 service. volume, practice expense, you say that it become
15 one of the criteria that indicate perhaps significant
16 change. So you would say that new services, after period of
17 X, be one of the ones that you automatically consider under
18 these automatic reviews.

19 DR. REISCHAUER: That makes a lot of sense but I'd
20 want to look at the information and see whether it was like
21 the engineering curves in manufacturing where what you see
22 is after two years a reduction of 10 percent, after three

1 years 15 percent. And so you might not want a single
2 review. It might be easier really to put in a function for
3 this stuff. But it depends.

4 MR. MULLER: That's why I ask what the
5 distribution of that curve is. If it's that kind of step
6 function in a predictable way for 90 percent of procedures,
7 then you can feel fairly comfortable. If it's more bell
8 curve, you obviously think about it in a different way.

9 DR. SCANLON: I think there are two broad things
10 about the context that we should at least make note of here.
11 One was an issue that came up yesterday.

12 It you're going to have the right fees we have to
13 invest in the information and the process to generate them.
14 And I think that, in part, relates number five, which is
15 going to be the most expensive of these recommendations to
16 implement.

17 We should underscore that given the amount of
18 money we spend with these fees, making that investment is a
19 prudent and wise thing to do. I would like to underscore
20 that.

21 The second thing is, while we're talking about the
22 RUC today and the work component, the issue of misaligned

1 physician fees applies to all three components of the fee.
2 And we should remind people that there needs to be work on
3 all of them to keep them all in line if we expect the
4 incentives to be appropriate in terms of services.

5 Again I guess I think that fifth one really is the
6 most important. And I guess I'm not sure that I like it as
7 five, as opposed to our primary recommendation should be
8 that the Secretary make sure that all procedures are
9 evaluated periodically so that they all are in line, makes
10 the investments necessary which may involve doing new types
11 of data collection that are not currently part of the
12 process and we haven't really talked about that. We've
13 talked about analysis of information and we've talked about
14 a panel. But we haven't talked about how do we generate new
15 information that would actually be helpful in this process.
16 I think that might be something to consider.

17 Recommendation one about the RUC composition makes
18 me nervous on a couple of counts. Glenn, your
19 characterization of it is a whole lot different than the
20 language that's in the recommendation. I think if I were a
21 lawyer I could think of a myriad of ways to implement the
22 recommendation without necessarily changing the RUC in the

1 way that some may have in mind.

2 And so the question would be should our language
3 be more explicit in terms of what we have in mind.

4 Given that, I guess I go to what should be the
5 goal in terms of representation on the RUC? Kevin made a
6 reference to the Senate model. I guess since we're in this
7 context we have as the alternative the House model. Well,
8 Delaware and Vermont still get one member each. So there's
9 a question within the RUC of what kinds of membership do you
10 need? What kinds of specialty representations do you have
11 to have in order to make it an effective body?

12 It may not be in proportion to the Medicare
13 service composition. There's the composition in terms of
14 expertise. And I think we need to think about that.

15 The last point would be in terms of saying why we
16 need to do this, I think the comparison of the 42 percent
17 and the 30 percent, we need to look at the specialties that
18 are the 30 percent, what share of E&M service, what their
19 E&M services are of Medicare. Because other people in those
20 other specialties that don't have the majority E&M are still
21 providing E&M codes. So it's not quite a fair comparison.

22 We don't want to build a case that can be chipped

1 away.

2 MR. HACKBARTH: I just want to underline Bill's
3 very first point about having a strong statement here, which
4 I think goes to the CMS resource issue. Chronically we --
5 and I mean the whole system -- loses perspective on the
6 allocation of resources. We chronically underfund CMS and
7 then pay out huge sums of money based on inadequate
8 information, inadequate data, inadequate analysis. That's a
9 theme that we've mentioned in the past. I think this
10 context is the place where we should once again pound that
11 drum.

12 MS. BURKE: Let me begin by underscoring exactly
13 what Glenn just finished with, and that is I think this is
14 an opportunity for us to underscore once again garbage-in,
15 garbage-out. That here, as in many cases, the quality of
16 the information ultimately will either make us or break us.
17 And we are shortsighted to essentially spend little in the
18 way of gathering the information and evaluating it and then
19 essentially spending it poorly based on bad data. So I
20 think here again we have that opportunity to state it and we
21 ought to state it absolutely clearly.

22 I want to agree with many of the points that Bill

1 has made. The overall theme in that, our desire to make
2 sure that the payment system is fair and accurate, is the
3 right theme. I am concerned that the structuring of the
4 recommendations masks that just a touch.

5 I am also concerned to start with with
6 recommendation one and whether or not we need to state
7 explicitly what it is that we are trying to achieve. I
8 worry any time we get into a percentage allocation of seats
9 or anything else because the information can change, the
10 impact can change. And it does mask the fact that there are
11 a variety of people that are involved at a variety of
12 levels. A straightforward 30 of this and 30 of that may not
13 ultimately achieve what it is that we want.

14 So in trying to state our goal in terms of making
15 sure that there is fair and appropriate representation, to
16 make sure that the assessment is a fair one, I think is the
17 goal. But I worry about not stating that clearly enough and
18 then getting into one of these and one of those because I
19 think that's really not ultimately what it is we're trying
20 to achieve.

21 With respect to recommendation two, I think again
22 it's linked to one, which is what you want is the right mix

1 of people with a broad range of expertise who can inform us
2 on all aspects of this. I think there's some combination
3 here in terms of how we gather that information. So I think
4 we just may want to step back and think about what we're
5 trying to say with both of those recommendations, in terms
6 of both physician mix as well as additional information that
7 we need.

8 Again, I think starting out by stating what it is
9 we think we need in terms of getting the right information,
10 based on having done the kind of research that Bill noted
11 and Glenn noted as well, having provided enough resources.

12 Again, I think the point made about the combining
13 of three and four, I am fundamentally -- well, I don't want
14 to say fundamentally opposed.

15 I am very concerned about four because I think it
16 leads to the kind of automatic behavior that doesn't
17 necessarily reflect what we really want to do, which is to
18 make sure that there is appropriate timely review of a broad
19 range of things.

20 I think again the suggestion that whether it's a
21 criteria under three, whether it is a note that needs to be
22 they made that essentially more newly or recently introduced

1 relative values for new services ought to be reviewed on
2 some frequent basis. As Bob suggests, that maybe within two
3 years, it may be within five, it may be every two years.

4 And so to suggest that we automatically reduce
5 relative values after a specific time would suggest that
6 kind of knee-jerk reaction that again leads us back down the
7 wrong path, which is that really the right kind of
8 thoughtful review isn't occurring.

9 I think our point here is that there ought to be a
10 review. There ought to be a fair process for determining
11 what needs to be reviewed, whether it's a new procedure or
12 one in which circumstances have radically changed. I just
13 think we need to think about how we combine those and what
14 the emphasis is that we specifically want to suggest.

15 Again it ties as well to five, which is we want to
16 make sure it's valid. As Bill suggested, we want all the
17 components looked at, not just one component, because all of
18 them add into this sort of three-part calculation.

19 Again, I think it's three, four and five in some
20 way reconfigured, so that we send the right message. I
21 think the work that you've done here -- and like Glenn, I
22 have learned a great over the last few meetings in hearing

1 about the RUC process works, its strengths and weaknesses.
2 I think the comments made by folks that are here as well as
3 the work done by the staff has been very, very helpful. I
4 think we're going in the right direction but I think there
5 are nuances here that need to be altered a little bit.

6 DR. NELSON: I generally support the
7 recommendations.

8 I would like to have us acknowledge more
9 explicitly the fact that there are factors that go into
10 volume changes other than just mispricing. In the growth of
11 imaging pricing is one of the factors but our intolerance of
12 uncertainty if answers can be achieved safely, regardless of
13 the cost consequence in many cases, is another factor.

14 Neither American patients nor physicians like to watch and
15 wait if there is a way to get an answer in the shorter term.

16 The growth of lab services is another example
17 where obviously the volume is going up, although the prices
18 haven't changed, because physicians are adhering to practice
19 guidelines that call for doing laboratory services to track
20 the diseases that are under discussion.

21 I think that four should stay as an independent
22 recommendation but I think that it should be changed so that

1 the Secretary should automatically review and consider for
2 possible reductions the work relative values for recently
3 introduced services.

4 The reason for that is because even a couple of
5 services that are arbitrarily reduced could be important.
6 For example, the codes that were introduced for coordination
7 and counseling. There is no justification for reducing
8 those services when they already are not being adequately
9 provided.

10 Another example is review of a home health plan.
11 So those are situations in which an automatic reduction
12 could be counterproductive.

13 I support the first draft recommendation without
14 being too explicit in terms of composition. And I agree
15 with Sheila's point about it being hazardous to arbitrarily
16 start allocating slots or seats. In my view it makes more
17 sense to have this general recommendation and allow the RUC
18 itself to consider changes that it believes might make it
19 better suited to do its job.

20 MR. HACKBARTH: On recommendation one, if you just
21 read through the recommendations and you're not reading all
22 the text, I'm concerned that some people may misinterpret --

1 not know whether recommendation one is talking about the RUC
2 or the subsequent new panel that we refer to later. So as
3 we work to the final version of the language, I think we
4 need to be more clear.

5 DR. SCANLON: Or even the physician practice panel
6 that exists.

7 DR. NELSON: If I could add onto that, Glenn,
8 that's an observation that came to me. When I first read
9 the recommendations, I wasn't sure whether we were talking
10 about replacing the RUC or what the relationship would be
11 between this recommendation and the second one.

12 So I think it -- in the first place, I think it
13 would be a terrible mistake to replace the RUC if for no
14 other reason -- and there are many reasons. But among them
15 the fiscal note would be considerable because it involves a
16 tremendous contribution of staff time and voluntary effort
17 among the RUC and its advisory committees that if it were a
18 governmental entity probably would have to be compensated in
19 some fashion.

20 I think the relationship of the update committee
21 and this other triage committee that I see as having focused
22 responsibility on identifying possibly overvalued services

1 might be made a little more explicit, identifying them as
2 having separate tasks to some degree, with the second
3 committee having some sort of oversight responsibility that
4 would be more proximally related to what CMS is doing.

5 DR. MILLER: [off microphone] Could you just give
6 the last part one more pass at it? When you said oversight
7 what you were thinking there. I just wasn't quite --

8 DR. NELSON: That probably wasn't the best word I
9 could use, the first word, triage. There has to be some
10 group who will pick up on overpriced services that the
11 process has missed.

12 DR. MILLER: [off microphone] And you're seeing
13 that as the second group?

14 DR. NELSON: Yes.

15 DR. MILLER: [off microphone] I think we're
16 seeing it that way, too.

17 DR. CROSSON: One of the reasons that I think we
18 took this topic up was the concern that was raised here, I
19 think it was in September by Bob Berenson, about the passive
20 devaluation of E&M services and the impact that that is
21 already having, as a matter of fact, on physician manpower,
22 particularly the flow of young physicians into primary care

1 services. I think then obviously the impact that that is
2 having and can have in the future on access to primary care
3 for beneficiaries. I think that even surpasses the equity
4 issue that we were talking about earlier in terms of
5 importance.

6 So as I looked at the recommendations, I think I
7 generally support the direction of the recommendations. The
8 concern I had was a question of whether they actually will
9 go far enough fast enough to deal with the problem.

10 Dr. Rich, when he was here last month, said that
11 in fact the RUC operates on a fact basis, as opposed to a
12 political basis that was mentioned earlier. I think
13 accepting that on its face, you're left with the problem
14 that the rate of introduction of procedures and the relative
15 higher cost of procedures compared with E&M services has the
16 impact, as it has had already, of passively devaluing E&M
17 services.

18 And I can't imagine that that's necessarily going
19 to stop. I think the primary care physicians could
20 potentially be more innovative in developing new ways to get
21 paid under E&M services, but so far they haven't and I
22 actually don't think that's the case. Whereas, technology

1 is developing more procedures all the time and they are
2 expensive and becoming more so.

3 I guess the question I would have is again, are
4 the recommendations going to solve the problem in a time
5 frame that will materially impact on the problem that we
6 identified in the beginning? And if not, is there some
7 further analysis that we could do to look at, for example,
8 ways to protect or to at least partially hold harmless the
9 payment to E&M services within the construct of budget
10 neutrality? Would that be something that we should look at
11 for some further work?

12 MR. BERTKO: I'm going to follow some of Jay's
13 comments up in a slightly different direction.

14 First I want to say thanks. A good report for
15 educating us on the work of the RUC and the issue.

16 Mine is more along the lines of looking at the
17 spending implications that you have built into all of these.

18 One is a prime implication, I completely agree,
19 that budget neutrality moves it all around. But there could
20 be a second implication, and there's some evidence at least
21 in our under-65 population that in fact having more
22 incentives to use primary care docs actually lowers the

1 costs. The number of office visits may stay the same but
2 the average cost of an office visit actually is lower. Now
3 this was from a different set of incentives so I guess I'm
4 suggesting that you look for some evidence for this.

5 Secondly, on the basis of episode-based stuff,
6 which I know a different group of you is doing, it's my
7 perception -- although I don't have any facts -- that in
8 fact when someone goes to a specialist they generally ring
9 up a greater series of tests, procedures, higher cost
10 procedures than if they had adequate treatment from a
11 primary care.

12 To go along then, finally, with Jay's comment
13 about the long term view of this, I think your staff work on
14 access for new patients show that there is great access for
15 a new patient to specialist but not quite as good access for
16 primary care. I completely support Jay's comments about
17 having longer term incentives to make sure primary care
18 physicians are available to this population.

19 So my suggestion is perhaps no change with
20 anything you uncovered might be turning to something that
21 says possible reduction in costs from a variety of
22 circumstances. And that would be another reason yet to do

1 this.

2 MR. SMITH: Carol, Dana and Kevin, thank you. Let
3 me join my colleagues in saying how much I've learned over
4 the last several months and I feel both more comfortable and
5 much better informed than I did when we started down this
6 road.

7 Let me talk briefly about each recommendation.

8 Glenn, I share your increased comfort with the RUC
9 as a result of the process and the conversations. But I
10 also share Bill's unease with recommendation one. It
11 suggests, and Bill used the right language I think, that
12 there's some sort of underlying representative formula here
13 which is the desired good.

14 Maybe there is but we don't know what that formula
15 is, even if that would be the right way to go.

16 I'm much more concerned with the agenda of the RUC
17 than I am with the composition of the RUC. In that sense
18 I'm uneasy about recommendation one unless we can make it
19 clear that we don't think there is some knowable bright line
20 composition which is represented. I don't think that's what
21 we want. To the extent that we're playing with a
22 representative Senate model it seems to me we do want a

1 Senate model.

2 But in a zero sum game, which is an important
3 piece of insurance here, setting the agenda is far and away
4 more important than tinkering with the composition of the
5 RUC at the bottom. So recommendations two, three and four -
6 - and I disagree little bit with Bill on recommendation five
7 in terms of its relative importance. But two, three and
8 four seem key to me.

9 Sheila, you had expressed, I thought, some concern
10 about two. It seems to me that one of the reasons that the
11 RUC agenda is tilted in the wrong direction is that CMS
12 doesn't have the resources to do its job and that this is
13 explicitly aimed at that problem. And that seems to me to
14 be right. This isn't an appropriate job for the RUC to do.
15 It's a job for CMS to do, and to instruct the RUC as to
16 where it would like to go. And some sort of committee of
17 the kinds suggested in this recommendation seems to be
18 right. And probably the job of that committee should
19 incorporate recommendation three in following the
20 statistical indications that something is amiss.

21 Four, it seems to me that what we know -- and Bob
22 used the right analogy, I think, in thinking about the

1 manufacturing productivity curve. What we know is that we
2 do get better at doing things the more and the longer that
3 we do them. And that presumption ought to be built in to
4 the relative value unit. When we adopt a new code, it seems
5 to me, we ought to assume we're going to get better at it.

6 Alan, I think, offered a useful way out. Rather
7 than get rid of recommendation four and put it into
8 recommendation three as another possible trigger, that we
9 would presume reduction but that the Secretary would be
10 required to find or the commission would be required to find
11 that there wasn't compelling evidence in the contrary.

12 So I think we can write this so that we presume
13 improvement and we've got a bailout mechanism that doesn't
14 require -- they can get triggered before the RUC has to
15 itself find that we've screwed this one up.

16 So something along the lines of what Alan
17 suggested, I think we ought to be able to work out that
18 language.

19 On five, I am concerned about spending an enormous
20 amount of money, Bill, on stuff that hasn't been reviewed
21 and has a tiny presence. I don't know how to square that
22 circle. It obviously would be good to make sure that

1 everything got reviewed over some period of time, but it
2 does seem to me that given the very large size of the
3 spending necessary to do everything else well that we don't
4 want to mandate that a big chunk of that scarce resource get
5 devoted to things where the consequences of the review could
6 not be anything other than trivial because the spending in
7 that area is trivial. I think we need to think about how to
8 do that.

9 DR. SCANLON: I obviously would want to advocate
10 an intelligent review, where you don't do the same thing for
11 every procedure. I guess my concern would be about the idea
12 that we're going to rely on analyses on this panel to
13 identify all of the problems. I think that they're not going
14 to be successful. There are going to be problems that are
15 going to go undetected until we happen to look at
16 potentially random samples at different points in time.

17 There can be levels of effort. If you're
18 comfortable at one stage you don't go on to another, more
19 expensive, stage.

20 MR. HACKBARTH: Could you put up recommendation
21 four for a second? I just want to make sure that I
22 understand what David is proposing.

1 What I heard you say, Dave, is that this would be
2 the basic mechanism but the Secretary would have an
3 opportunity to say these codes are excluded from that
4 general rule, that we've concluded that this innovation
5 curve does not apply to them. For example, perhaps some of
6 the services Alan mentioned. And then the list goes on,
7 edited.

8 MR. SMITH: [off microphone] The presumption
9 would be a downsloping cost curve. And may be not even the
10 Secretary to have the opportunity but the Secretary to have
11 the obligation to consider whether or not a new code ought
12 to be excluded.

13 DR. MILLER: I'm going to say this just a little
14 bit differently, because we're going to have to get this
15 down on paper.

16 Here's a way I could say back to you what I think
17 you're saying, is if you preserve this assumption -- and I
18 realize that other people have raised issues on it. But for
19 the moment if you preserve this assumption, let's just say
20 some of the other recommendations, we have this panel and
21 this group that are supporting CMS's process. I'm going to
22 give you a way of doing this.

1 That they develop information that says for any
2 new set of codes that come out in any year -- and there's
3 always a lot of them -- that they review that before it is
4 forwarded to the RUC and say by the way, these of those
5 codes will be subject to this, these of those codes will not
6 be subject to it.

7 Do you see it going into the RUC or coming out of
8 the RUC, is what I'm a little confused on?

9 MR. SMITH: [off microphone] I hadn't thought
10 about it going into the RUC but I'm not sure that that
11 doesn't work. Part of the problem though --

12 MS. BURKE: Mark, can you restate that because I'm
13 not sure I understand what you said.

14 MR. SMITH: [off microphone] Mark, it seems to me
15 that we want the providers of the service that is slated to
16 go down the cost reduction path to have an opportunity to
17 say to perhaps this panel oh no, it's inappropriate in this
18 case. In a couple of examples that Alan mentioned, and
19 there will be others, that a third task for this new
20 committee could be to advise the Secretary of which new
21 codes ought to be exempt from the presumption.

22 DR. NELSON: My words were should automatically

1 review and consider for reduction. But this would be after
2 the RUC had finished its process and we'll say six months or
3 one year after the code has been approved and paid. Then it
4 would be automatically reviewed.

5 MR. HACKBARTH: This could well have been written
6 by a lawyer. This is all about shifting the burden of
7 proof, which often is dispositive in these things.

8 As I understood the original recommendation, it
9 would provide the opportunity for the affected specialty to
10 come in and present data to show that no, this general rule
11 does not apply. And so that was built into my understanding
12 of this.

13 What I thought I heard you initially say, and this
14 is why I asked for the clarification, that you were creating
15 a second opportunity for the Secretary or the Secretary's
16 advisory panel or whoever to edit the list before it even
17 went to the RUC.

18 MR. SMITH: [off microphone] No. I think both
19 Alan and I were the back end of the RUC process rather than
20 the front.

21 MS. BURKE: I'm sorry. So what you're -- let me
22 just ask a fundamental question.

1 As I understand this recommendation, it is a
2 presumption. It is an automatic event that occurs absent an
3 intervention.

4 So let me ask the basic question. Are you and
5 Alan opposed to the automatic reduction? Alan is.

6 So Alan and I are in the same place about not
7 wanting the automatic nature of it to occur. Rather a
8 review should occur but not the presumption that it would --
9 it is this question of where the intervention occurs. In
10 this case, you have to prevent it from occurring.

11 You and I are suggesting a review occur, but that
12 there not be an automatic reduction absent a second review
13 that said this needs to be done. I think there's a
14 fundamental -- and David, you're on the side of --

15 MR. SMITH: Sheila, where I am is that there is a
16 rebuttable presumption that the reduction should occur. So
17 that the RUC is assigned a relative value to a new code. It
18 is slated to automatically move down a cost curve. But any
19 affected party can go, presumably to this new committee
20 that's described in recommendation two, and say there's
21 compelling and good reason why this shouldn't happen.

22 MS. BURKE: [off microphone] But you're

1 comfortable with the system that would have it automatically
2 occur.

3 DR. NELSON: You can't consider whether the work
4 has changed until it's been implemented, until it's been in
5 operation for a while. So you can't do it at the front end
6 of the RUC. It has to be a service that has become -- that
7 is now being paid for and has become used. And then after
8 some period of time you look to see whether the work has
9 changed.

10 DR. REISCHAUER: But we're acting like there's one
11 cost function for all conceivable new codes. And I think
12 that's crazy. I would assume that you might have six or
13 seven variants of this and you'd apply them. And one of
14 them would be flat. You'd assume there would be no
15 reduction.

16 MR. SMITH: [off microphone] Who would apply them
17 when?

18 DR. REISCHAUER: I think the second commission
19 might select one to apply to each new code at the start.
20 But one option would be no expected reduction at all because
21 of the nature of whatever is it that we're talking about
22 here. These codes are all over the line, the new codes.

1 MS. BURKE: So Bob, your suggestion, let me make
2 sure I understand. Your suggestion would be at the point of
3 the service being included, that a decision would be made by
4 a third party that would suggest that this is one that
5 should not automatically go down but ought to be under the
6 following review schedule? That that would be made
7 proactively at the point of including the service. This, in
8 fact, would not be the case for some.

9 So the suggestion is that this third party,
10 whether the RUC or someone else, would make a proactive
11 decision that there are certain services that are reviewed -
12 - there are certain services that are automatically reduced
13 but for an intervention. There are services that go into a
14 review of some time line at some point.

15 But similarly, all of the things that are already
16 in the code would also be under some time line. Not just a
17 five-year time line, but some newly revised time line that
18 takes into account new information about the frequency with
19 which it should occur.

20 I'm trying to understand all of these moving parts
21 and we're into about 12 sets of rules here.

22 DR. MILLER: Let me try and capture this

1 conversation.

2 I still think there is some disagreement around
3 the table here, so I'm not trying to articulate a position,
4 just something to shoot it.

5 MR. HACKBARTH: You got that part right. You're
6 off to a good start.

7 DR. MILLER: Let's articulate a process here.

8 This is now different than what we had up here.

9 so the process would work like this -- and it's
10 kind of back to what I was saying, because I think there's a
11 couple of things going on here.

12 First of all, I think it's important to track on
13 for the most part -- not for the most part. We've been
14 talking about new services here. New services that come in.
15 This connects to many comments that people have been making,
16 most recently, in my mind, Jay's comments that there's lots
17 of stuff that comes in. So these new services show up.

18 A way that this could work is CMS, as supported by
19 this new panel and this new data analysis that they're
20 doing, et cetera, could look at that list. And to address
21 the point that Bob is definitely making and it sounded at
22 times like David was making, would be to say all these

1 services aren't the same. This is a high piece of
2 technology that is going to disseminate fast. People are
3 going to learn how to use it. This baby is going to drop.

4 This is some other service, which I can't give you
5 a good example this second, like Alan's example, that isn't.
6 So that would move to the RUC.

7 Here's the \$64,000 question, and now we're more
8 back to what we put on the board to start the conversation.

9 They enter the RUC and you could think about this
10 two ways. They have an automatic path that drops unless
11 evidence is presented to the contrary. And the RUC
12 considers that. No, I'm telling you this technology is
13 different and it's not falling the way you're assuming or it
14 is. And it sort of shifts the burden of proof.

15 And my last comment is the other way you could do
16 that mechanism is to say it just triggers a review. It
17 doesn't have an automatic downward path.

18 I think those are the parameters that everybody's
19 kind of talking about.

20 MS. BURKE: I have to sort of visualize this. If
21 you visualize it -- I wish I had the little board thing.

22 If you visualize here are categories, these are

1 new procedures. And here is the category of current
2 procedures. Next the current procedures is a five-year
3 review that has currently in place. Then there are these
4 new things. And you have these two sort of strategies that
5 you can employ for the new.

6 The concern that I see is the automatic nature of
7 certain activities. But there are questions about things
8 that are coming in that we will gain experience from, and
9 the issues that Alan raises as to whether or not we have an
10 expectation of certain things occurring.

11 And then there is the ongoing process for the
12 current RUC, the current procedures that are in place. What
13 I think we need to step back and think about is what overall
14 is the combined procedure? What is the overall process,
15 both for the things that are coming in new as well as for
16 the things that are already in place.

17 Because some of the issues that arose in the
18 context of the paper are not just for things that are
19 introduced that are new but what occurs in the normal review
20 process that has things either increasing or decreasing and
21 the subsidiary effects when essentially you're in a budget
22 neutral environment. In which case things sometimes

1 decrease not because you specifically went after them,
2 because essentially you had to make these decisions.

3 We have touched on a couple of those things but
4 overall there is this broader problem about what the
5 valuation of services is based on the knowledge that we have
6 and whether there are unintended consequences that occur
7 because of changes to certain things and not others.

8 And so we've spent some of this morning talking
9 only about the sort of things that are introduced new and
10 whether there ought to be a new method for determining
11 whether they go under review.

12 I am equally as concerned about what the process
13 is for the current and the unintended consequences that move
14 things around.

15 MR. MULLER: Why doesn't three capture that,
16 Sheila? Doesn't three capture that?

17 MR. SMITH: You're getting into CMS's job.

18 MS. BURKE: My concern is that we're separating
19 these things out, where I think what we ought to be looking
20 at is the overall process, and decide what happens over
21 time.

22 MR. MULLER: I would think maybe we can amend

1 three a little bit. My initial suggestion by saying let's
2 fold four into three was to say well, the presumption of
3 some new things -- maybe minimally invasive surgery 10 or 12
4 years ago, bariatric surgery in the last eight years has
5 grown a lot and so forth.

6 But if we're looking at the overall valuation of
7 procedures, and going to many of the points that Alan and
8 Jay and others have made, it may be -- just to quote words
9 here -- it may be sites of service, it may be volume. There
10 are a set of different triggers. And so I would say those
11 are the things that allow us to decide which of these many
12 procedures and values we look at.

13 I think one can answer that question to make the
14 new ones one of the triggered reviews under three, one can
15 then, as a secondary point, get into Bob's curve and decide
16 -- I see that as a secondary issue as to whether there are
17 kind of different time periods for different ones.

18 But I would suggest that therefore -- and we may
19 want it listed as the first of these lists after triggers
20 and so forth, as a way of putting weight to it. Or I would
21 say certainly, given our discussion over the last few years,
22 that the volume trigger is one of great importance because

1 that would capture, for example, the imaging one.

2 MS. BURKE: Let me ask the basic question. what

3 is the presumption on the part of the staff or our

4 presumption with respect to the current five-year review?

5 Do we leave it in place? Do we change it? Does it get

6 altered by the information that we're gathering here? What

7 is our stated intention with that, as compared to a new

8 review process, as compared to an automatic process?

9 DR. HAYES: With respect to the five-year review,

10 the presumption was that we would keep the process in place

11 but we would do a better job of identifying what services

12 need to go into through that process. Right now it's

13 largely a process of physician specialty societies

14 identifying --

15 MS. BURKE: Right, I understand that.

16 DR. HAYES: So we would use some of these tools,

17 these data oriented tools here.

18 MS. BURKE: So that recommendation three is to

19 influence the decisions on the five-year review? So we're

20 assuming five years is the right number?

21 DR. HAYES: Yes. Only because that's what

22 historically has been the practice and because that's what's

1 in the law.

2 MS. BURKE: But it seems to me if we're suggesting
3 a whole new process we ought to look at the fundamental
4 question is a five-year review the right answer? Is this
5 supposed to suggest -- when you say should institute
6 automatic reviews of services that have experienced -- what
7 if they've experienced in two years or in three years or in
8 the first year? Do we want to leave in place five years
9 because that's what we think is the right policy?

10 DR. MILLER: That's kind of what brought us to the
11 automatic and the discussion of new types of services. In a
12 sense we were saying -- and this is what you're taking on,
13 but I just want to articulate it.

14 So you have these existing services. They move
15 from five to five -- and of course there is annual work that
16 goes on. But they move from five to five. And this says
17 things are happening here that really raise questions about
18 it.

19 Meanwhile, you have all these new codes and this
20 process that we sort of sorted through of does it have a
21 falling trajectory, would apply to these new codes. And of
22 course, all codes or any set of codes that people think is

1 reasonable to review, would be brought into the five-year
2 review.

3 So you'd have the existing sort of hitting five-
4 year reviews, new ones being looked at with either these
5 automatic or not so automatic drop-off, however we decide.
6 And then everything hitting the five-year review based on
7 information that suggests is needs to be reviewed.

8 MS. BURKE: So the adjustment occurs in the course
9 of five years. Under this scenario if you have a new thing
10 that has occurred and the decision is either automatic that
11 in two years something happens or whenever.

12 So in between the five years you're also doing
13 interim adjustments to those but having no impact on
14 anything else?

15 DR. MILLER: [off microphone] To new services.

16 MS. BURKE: To new services.

17 MR. HACKBARTH: I've got to cut this off. We're
18 behind schedule and I think we've gone over the point where
19 we're -- we're past the point of diminishing returns right
20 now.

21 I think we've got some issues framed and some
22 concepts. I think that Sheila's idea of drawing some

1 pictures here, sort of flow diagrams to describe different
2 options, may help us get together.

3 We do have four people who have been waiting
4 patiently. And I want to give them a chance to talk before
5 we move on.

6 MR. DURENBERGER: Thanks.

7 I wanted to start by complimenting the staff, and
8 I mean the staff in general. We were visiting before the
9 staff showed up in somebody said well, we should have five
10 people here this morning. And I think we had closer to 30
11 off the Hill. And Mark and Glenn and everybody else on the
12 staff, it's a compliment to you, that all those people
13 showed up. Many of us had the opportunity to listen to what
14 they were saying.

15 Among the things that they talked about, and I
16 like what Bill said about intelligent review rather than
17 intelligent design. This seemed like an intelligent review
18 until a couple of minutes ago, as opposed to intelligent
19 design.

20 But Sheila is getting us at the intelligent design
21 thing, just as she did back in 1989 when we --

22 [Laughter.]

1 MR. DURENBERGER: I know it doesn't sound like it.

2 I know it didn't sound like it.

3 MS. BURKE: Please do not go there on intelligent
4 design.

5 MR. DURENBERGER: The reality is, from where I
6 from, listening to these people talk about our biggest
7 problem is volume and our solution is pay for performance
8 but we don't know what the hell it is, please tell us,
9 really gets me focused on this whole work that we started --
10 while we may have started it on the RUC or whatever it is --
11 the way it's now evolving. We know physicians drive 87
12 percent of the money in the system. And driving this system
13 towards real value is critically important.

14 We did the best we could in the intelligent design
15 stage. And in the intelligent design stage you have to
16 accommodate the politics. And in those days it was either
17 the AMA politics or specialty politics or whatever. So you
18 accommodate, in determining what is relative value not just
19 for work but for everything, to your politics.

20 And basically that was given to what is now called
21 the RUC. And that's where the five-year analysis and
22 everything comes out of.

1 What I think we are trying to say here is that
2 five years and organized medicine shouldn't drive
3 decisionmaking. Information should drive decisionmaking.
4 And that's why the importance of this second recommendation,
5 and thinking of it not as another commission or whatever it
6 is. Information needs to drive decisionmaking on the part
7 of third-party payers, on the part of Medicare, on the part
8 of physicians themselves. The medical education enterprise
9 needs to be driven by this kind of information.

10 So I wanted to underscore, and in response to
11 where Sheila was at right at the conclusion here, I'm for
12 dropping the five years. I'm for dropping all the intricate
13 detail of the processing and focusing our recommendations
14 and whatever we want to say about process on the critical
15 importance of information driving decisionmaking, not 23
16 representatives of organized medicine, in the absence of any
17 other effort by CMS or whatever, driving decisionmaking. I
18 think that's the important contribution we're making.

19 The only added thing is that MedPAC should never
20 give up on being involved in that process because we do as
21 good a job as CMS or anybody in this place of developing the
22 information, asking the question that should be driving

1 this. So that doesn't have to be in a formal recommendation
2 but I think we need to say that to ourselves because of the
3 importance of what lies behind this relative value
4 discussion, that this is a very important investment as an
5 advisory board to Congress we need to make.

6 DR. MILSTEIN: Previously commissioners have
7 discussed and been somewhat self-critical about whether or
8 not some of our individual decisions in narrow policy silos
9 are really adequately interfaced in terms of our broader
10 objectives. I think this set of decisions is a very nice
11 case in point.

12 Let me just move this into two practical
13 directions, one in relation to recommendation number two and
14 the other perhaps in the direction of recommendation number
15 six, which I realize is TBD.

16 Number two, if our aspirations are both to
17 significantly improve the quality of care the beneficiaries
18 are receiving, and also to provide some advice that promotes
19 the sustainability of the Medicare program, I wonder if we
20 might consider adding onto the task of our review panel,
21 this second wave review panel, whatever its name may be, the
22 bringing to bear in the relative weighting of physician

1 codes cost-effectiveness, particularly as it pertains to the
2 20 percent of services for which we do have cost-
3 effectiveness information.

4 One of the observations that Peter Neumann and
5 David Eddy made when they came to talk to us about this last
6 spring is that yes, it's true, we don't have information on
7 either cost-effectiveness or both for 80 percent of what
8 we're currently spending Medicaid money for.

9 But for 20 percent of services we do have
10 information. And there is a subset of those 20 percent of
11 services that have a very, very favorable profile of quality
12 delivered to Medicare beneficiaries relative to what it
13 costs.

14 A case in point would be smoking cessation
15 counseling. Currently it's not something for which any kind
16 of adequate payment is made. And as a result, it doesn't
17 happen very much. And as a result, both the quality and the
18 affordability benefits of the Medicare program are being
19 lost.

20 And so my first suggestion is that we consider
21 adding to the scope of responsibility of this second wave
22 panel the potential incremental weighting of those subset of

1 Medicare coverage services for which there is evidence of a
2 uniquely favorable relationship between health gain and
3 dollars spent.

4 Second point relates to my reference having to do
5 with recommendation six. Really I think it builds on Jay's
6 point about the current equilibrium, which I would agree
7 with Jay. I would describe it as a rapidly eroding
8 financial viability of high quality primary care. And
9 especially within primary care something that Alan has
10 frequently referenced, and I think in some ways Nick's
11 organization and Jay's organization exemplify, which is
12 physicians taking longitudinal accountability for quality of
13 care and care coordination. It's currently nowhere to be
14 found in the fee schedule. It's an absence that people have
15 commented on for probably at least 15 years but for which no
16 remedy is yet at hand.

17 And so I guess what I'm asking is that
18 Commissioners consider and the staff consider whether or not
19 as part of this set of recommendations, and in keeping with
20 Jay's comment about we have a serious problem that is pretty
21 far down the tracks. If we want to have a hope of reversing
22 it we have to make sure that the medicine that we're

1 introducing is strong enough, whether or not we ask that the
2 Secretary establish an E&M code that pertains to physicians
3 taking accountability for -- primary care physicians usually
4 -- taking accountability for coordinating all services that
5 a beneficiary is receiving. It's obviously not every
6 physicians' cup of tea. But for the physicians that are
7 willing to step up to the plate, take that accountability,
8 is it not time to establish and pay for that code in order
9 to, among other things, make the practice of longitudinally
10 accountable primary care more financially viable?

11 MR. HACKBARTH: Let me just pursue that for a
12 second to get some clarity, at least in my mind.

13 Jay framed the issue a little bit differently, at
14 least to my ear. And I'm putting words in Jay's mouth.

15 It may be what you want to do is that for a range
16 of primary care services have an additional conversion
17 factor and add on to the conversion factor. Because as a
18 policy matter we want to encourage good primary care. We
19 want to make it a financially viable thing. We want to make
20 it an attractive area of practice for physicians in
21 training.

22 I hear you saying something that's not necessarily

1 inconsistent with that, but it's a different approach, which
2 is to say a code for rewarding a particular activity.

3 DR. MILSTEIN: May I clarify my suggestion? First
4 of all, I support Jay's recommendation. It's directionally
5 excellent.

6 But I was trying to make the distinction between
7 paying primary care physicians more for each individual
8 visit. That, to me, is different than paying primary
9 physicians more for stepping up and taking accountability
10 for longitudinal care coordination along the lines of what
11 Alan has previously described the best primary care
12 physicians in America already do but aren't being paid for
13 it.

14 MR. HACKBARTH: What I was trying to get at is so
15 you see them not as inconsistent. You would favor both?

16 DR. MILSTEIN: Yes.

17 DR. CROSSON: Yes. And I didn't come ready to
18 write the regulations this morning.

19 But I was primarily getting at the fact that I
20 think the flow of new procedures and the flow of dollars
21 into them, because they're so expensive, is having an impact
22 on the payment for E&M services. And that some mechanism --

1 this could be, for example, creating a hold harmless pool
2 within budget neutrality within the RUC for E&M services, or
3 some other mechanism which would have the same effect on
4 neutralizing all or some of that disproportionate flow of
5 dollars over time would be a good idea.

6 MR. HACKBARTH: I really want to get to Nick and
7 Ray, but please bear with me.

8 One of the factual questions that I need sorted
9 out for me is the extent of passive devaluation of primary
10 care over the history of the RBRVS system.

11 If I interpret the data that we've seen, I don't
12 see a whole lot of passive devaluation. I see some increase
13 in the relative values and some loss on the volume side.
14 But the primary care share of the total dollars going out
15 has gone down. But it's not like it's fallen off a cliff.
16 That's something I just need to get straight in my own head.

17 The premise of your formulation is that's what
18 we're trying to counteract, is that passive devaluation.

19 A whole different approach is not to tie it to
20 that and just say as a policy matter we need more good
21 primary care in America and we went to increase the relative
22 payment rate. It's separate from the RUC process. The RUC

1 process is never going to produce it.

2 DR. REISCHAUER: We don't pay for things that way.

3 I mean, the whole RUC process. We should but that's like
4 re-thinking absolutely everything.

5 MR. HACKBARTH: That's what he's raising.

6 DR. HAYES: One way to deal with this would be to
7 consider the spending figures that we cited on page four of
8 the mailing materials, which shows that the portion of
9 spending went up from 36.5 percent in 1992 to 42.2 percent
10 in 2004.

11 MR. HACKBARTH: What's the '92 number? If we want
12 a longer-term perspective on that? This is just two years.
13 What I want to know is over the course of RBRVS how many
14 passive devaluation -- if we go back to 1992.

15 DR. HAYES: On page four we have spending figures.
16 36.5 percent --

17 MR. HACKBARTH: Oh, I'm looking at the wrong page
18 four. That's my problem.

19 DR. HAYES: We have 36.5 percent of spending went
20 to E&M services in 1992. That went up to 42.2 percent in
21 2002. And then later on we talked about how spending for
22 E&M services has started to --

1 MR. HACKBARTH: It went down to 40.7.

2 DR. HAYES: Down to 40.7.

3 The point to make here might be along the lines of
4 the following: yes, it could be that 2002 was kind of a
5 peak year because that was the year when the resource-based
6 practice expense RVUs were fully phased in. So we had an
7 increase in payment rates for E&M services in that year.

8 Now what we're faced is is a situation where
9 growth in other sectors, other parts of the payment system,
10 imaging and tests let's say, they continue to go up. E&M is
11 kind of where it is. The fee schedule is kind of fully
12 phased in. And we could be looking at a situation where
13 it's just going to continue to fall off. And that would be
14 the passive devaluation that we talked about.

15 MR. HACKBARTH: It's a relatively new phenomenon.

16 We actually went up in primary share or E&M share and now
17 that curve is tipped downward. You're saying it may well
18 continue down.

19 DR. KANE: To what extent is that just the
20 physician work piece and to what extent is the practice
21 expense contributing to that, too? Because that was the
22 part I remember really greatly having a big effect on E&M

1 relative to others.

2 DR. HAYES: If we look over the whole span from
3 1992 through 2002 or 2004, it was a combined effect of
4 changes in RVUs for work. They were reviewed during the
5 first five-year review and experienced an increase. And
6 then there was a transition to resource-based practice
7 expense RVUs, which was completed in 2002. So it was kind
8 of a combined effect.

9 DR. KANE: Would the devaluation also have a
10 combined effect? Because aren't practice expense RVUs also
11 reevaluated every so often?

12 DR. HAYES: Yes. They are subject to a five-year
13 review process just as -- starting now.

14 DR. KANE: So maybe we have a problem on both
15 sides of the -- maybe it's not just -- mostly we've been
16 focusing on the work component and I'm just wondering if the
17 practice component is also going to contribute to a shift
18 that may or may not be the direction you want.

19 DR. MILLER: Just to remind you, we've also gone
20 through what our agenda is for the physician fee schedule
21 broadly, which has been driven by many comments from many
22 Commissioners. And we do have an explicit set of work that

1 we're thinking about on the practice expense. This was a
2 part of our focus on the work piece of it.

3 But you are right, there are two different
4 components. We do have other sets of work aimed at that.

5 DR. MILSTEIN: Can I ask a follow-up question?

6 So far the dialogue on our basis of evidence has
7 been E&M codes. But what Jay is referring to and what I was
8 referring to is E&M codes for primary care. Do we have a
9 clear signal of that phenomenon, given that that's the topic
10 that we're trying to resolve?

11 DR. HAYES: We can put that together for you.

12 It's about 20 percent of spending. Your question, I think,
13 is how has that share been changing over time?

14 DR. MILSTEIN: Yes.

15 DR. HAYES: Sure, we can do that.

16 MR. HACKBARTH: Good point, Arnie.

17 DR. SCANLON: On that, as we've been talking about
18 this passive devaluation of primary care or E&M codes due to
19 the introduction of the new procedures, there's another
20 phenomenon that goes on in the fee schedule and that is the
21 averaging effect. The averaging effect, in terms of
22 practice expense and malpractice, actually takes money from

1 some higher priced specialties and puts it into primary care
2 physicians because the allocation of their E&M code expenses
3 is put into a pool and averaged. And so some people, the
4 money they're getting for malpractice for an E&M code is
5 less than what their actual malpractice costs are.

6 This is a phenomenon that has gotten clearly more
7 relevant in the last few years as we've had very large
8 increases in malpractice costs, as well as differences
9 across specialties. That's something else that's going on
10 here. There's a lot of distortions in this fee schedule.

11 DR. CROSSON: Glenn, just one more point on the
12 practice expense piece.

13 I believe last month we also saw, if I remember
14 correctly, that there were only 12 specialty organizations
15 who had applied for the opportunity to review the practice
16 expense piece. As I remember them, they were all procedure-
17 based specialties.

18 MR. HACKBARTH: Okay. Having delayed Nick and Ray
19 this long, everybody else including me has to turn off their
20 microphone and they can speak without limit.

21 DR. WOLTER: I don't think I'll take you up on
22 that offer.

1 I think draft recommendation two is potentially
2 very important. What I remember from last month and then
3 some of the conversation this month, I think there's an
4 interest that that panel take on the issues around physician
5 payment in a strategic way. And whether that be primary
6 care needs or geriatric or mental health. We all have
7 things that we put on the list that may be right now there's
8 not a place in the system where that kind of strategic
9 thinking is going on.

10 The recommendation seems a bit narrow to reviewing
11 RVUs. And the text also doesn't pick up much about that
12 more strategic or potentially strategic role for this panel.
13 So I just raise that as a question, do we want to include
14 that in the text and maybe more so in the recommendation
15 itself?

16 MR. HACKBARTH: That would go in Jay's direction,
17 be compatible.

18 DR. WOLTER: Yes.

19 One other thing I would just say, I know you
20 wanted to stop on this. But number four really doesn't make
21 sense to me. I think Bob said it right. There may be
22 different cost paths for different services. Some would go

1 down, maybe most. Some might stay flat. You might even
2 thing of a few that could go the other direction.

3 It would make a lot of sense to have new services
4 be one of the triggers for review. But it's hard for me to
5 predict or feel like I have the expertise to suggest that
6 they would all automatically go down.

7 So just from for my point of view on that one.

8 MR. HACKBARTH: So your view is similar to Ralph's
9 on that.

10 DR. STOWERS: I'll also be brief.

11 I just wanted to get back to what Jay said
12 earlier, about what kind of brought us to the table was the
13 discrepancy of physician reimbursement and not just the
14 codes and that kind of thing.

15 It's a great chapter. And just one point I want
16 to make is that I think we've all come to the realization
17 that it's RUC's responsibility to give us unbiased
18 analytical values of the codes that we're dealing with. But
19 the RUC itself is not and cannot be totally responsible for
20 the outcome in physician income differences.

21 And I don't think that recommendation two is
22 either going to settle that either because they're going to

1 serve a function in working with the RUC and identifying
2 codes and that kind of thing.

3 And many times RUC has tried to do the right thing
4 in providing values and the existence of codes for oversight
5 management, recognizing the need for chronic care management
6 in Medicare and so forth. But CMS chose not to pay for
7 that.

8 So I think where I'm coming around to is that we
9 need to be looking, I think, somewhere in Sheila's diagram
10 as who in the system is going to be responsible for taking
11 an overall look at physician income? And I think one of the
12 most fun parts for me, back on the Physician Payment Review
13 Commission, was that we did and we looked at all of the
14 factors involved in discrepancy and access to care through
15 proper specialty mix and that kind of thing.

16 So as I think Dave hinted a while ago, I think the
17 MedPAC would be a great place to have that happen. But I
18 think someone in the system needs to latch onto that
19 responsibility and take that on. I think I'm hearing that
20 starting to happen here. So I think it's a good phenomenon.

21 MR. HACKBARTH: Okay, thank you very much.

22 I'm sorry, Jennie.

1 MS. HANSEN: I just wanted to lend my voice to
2 that side of the table to talk about the role of MedPAC
3 reframing the primary care piece and looking at the episode
4 longitudinal aspect of it. So I think this is an important
5 discussion.

6 And if the transitional aspect is to increase the
7 E&M for primary care, that might be an interim measure. But
8 to really put a bookmark to really the longer range
9 discussion, to certainly get going into primary care,
10 realizing where med students are going.

11 My son just graduated from med school and I
12 certainly see -- and he's gone on the side of proceduralists
13 as an orthopedic surgeon. But here we're thinking about
14 practitioners -- sorry. But for the next 30 or 35 years we
15 really need to make sure there's going to be an ample supply
16 of primary care for people with comorbidities.

17 MR. HACKBARTH: Thanks.

18 Cristina is doing our next presentation, which is
19 on payment adequacy for physicians.

20 MS. BOCCUTI: This morning I'll be presenting an
21 assessment of payment adequacy for physician services.
22 First I'll go over two indicators in this assessment that

1 you haven't seen yet. Those are specifically service volume
2 and ambulatory care quality. Then I'll review findings you
3 saw just a few weeks ago at our November meeting,
4 beneficiary access to physicians and physician supply. Then
5 I'll discuss expected cost changes for 2007.

6 In our payment adequacy we look at changes in the
7 use of services by Medicare beneficiaries. As we look at
8 claims data through 2004 we do not see decreases in volumes,
9 at least among broad categories of services shown in this
10 chart. Rather, across all services per capita volume grew
11 about 6 percent between 2003 and 2004. So this growth, as
12 you know, includes increases for service intensity as well
13 as units.

14 Looking across the years you see that imaging
15 continues to have a high growth rate. In 2004, 11 percent
16 per beneficiary. For the first time the volume of the other
17 procedures categories grew more than tests, but both were
18 pretty similar. Other procedures grew 9.3 percent per
19 beneficiary, and tests 8.9 percent.

20 The other procedures category includes the
21 subcategory called minor procedures. That category grew the
22 fastest in 2004. Physical therapy codes had the greatest

1 volume increase in this category. Drug administration codes
2 grew as well, some of which may be due to the new ability
3 for physicians to bill multiple times for chemotherapy
4 administration in a day.

5 Overall, we saw a couple of instances of volume
6 decreases which can be explained by general trends in
7 practice.

8 So the cumulative impact of these annual increases
9 in volume is shown by the dark, upwardly sloping line that
10 you see on that chart. So as you know, these increases have
11 resulted in substantial increases in Part B spending. In
12 2004 alone CMS recently estimated that spending on physician
13 services increased by about 13 percent. Using information
14 supplied by the AMA, CMS has noted that although some of
15 these volume increases are related to improvements in health
16 care quality, much of the increases cannot easily be
17 explained by changes in new medical evidence and
18 technologies.

19 For this year's payment adequacy analysis we begin
20 to examine the quality of ambulatory care through Medicare
21 claims data. For our analysis we used a new claims-based
22 measure set which we're calling MACIES, which is the

1 Medicare ambulatory care indicators for the elderly.
2 Because this analysis is new I'm going to take a moment to
3 give you just a little bit of background on the measure set.

4 MACIES are derived from the ACE-PROs which were
5 developed nearly 10 years ago by a research team at RAND for
6 our predecessor, PPRC, the Physician Payment Review
7 Commission. Last spring we convened an expert panel of
8 physicians, clinicians, and researchers to review and update
9 the original indicators to reflect current basic clinical
10 standards of care.

11 The MACIES focus on two types of measures, the
12 percentage of beneficiaries who received clinically
13 necessary services for their diagnoses, and the percentage
14 who had potentially avoidable hospitalizations directly
15 related to their diagnoses. Because the MACIES are based on
16 claims data they're a resource efficient method to monitor
17 potential underuse. But they, of course, cannot account for
18 reasons why patients do not receive necessary care.

19 For purposes of our update analysis we're tracking
20 these quality indicators in the aggregate. Further analysis
21 can compare MACIES for specified subpopulations.

22 On to the results. I'll take you through this

1 table here. The table tracks changes between 2002 and 2004.
2 The numbers in the table refer to the number of indicators
3 within each medical condition that showed improvement, no
4 change -- we'll call that stable -- or worsened. The
5 medical conditions are listed at the top. The cancer
6 category includes breast cancer and colon cancer.

7 As you can see, most of the indicators we measured
8 were steady or showed small improvements between 2002 and
9 2004. Among 38 measures, 22 showed improvement and 13 were
10 stable. This suggests that beneficiaries with selected
11 conditions were a little more likely to receive certain
12 necessary services for their condition and averted
13 potentially avoidable hospitalizations in 2004 compared to
14 2002.

15 In only three out of 38 conditions did we find a
16 decline in quality as defined by our measures. All three
17 were related to breast cancer. We found small declines in
18 general mammography screening for females and clinically
19 indicated imaging for women with a history of, or a new
20 diagnosis of breast cancer. These slight declines are
21 consistent with ones recently found by NCQA for health plans
22 reporting HEDIS data.

1 There's a couple more findings that I want to
2 mention on this analysis that aren't specifically indicated
3 on that table. We found that for several conditions
4 declines in potentially avoidable hospitalizations occur
5 concurrently with increases in the use of clinically
6 necessary services, or you could call them process measures,
7 for that same condition. So in taking diabetes as an
8 example, we saw lower rates of short and long-term
9 complications such as diabetic coma and non-traumatic
10 amputation concurrent with higher rates of necessary care
11 such as lipid and hemoglobin testing.

12 In addition, we also looked at the number of
13 categories where the share of beneficiaries getting the
14 needed service was at least two-thirds of that share. We
15 found that in 20 out of the 32 measures for necessary care
16 at least two-thirds of beneficiaries receive indicated care
17 for their condition. That was in 2004 we took that measure.

18 In November I presented some findings on
19 beneficiary surveys on access to physician services, so I'm
20 just going to review that very briefly. The majority of
21 beneficiaries reported little or no problems scheduling
22 appointments and accessing physicians. A small share of

1 beneficiaries, however, reported having problems,
2 particularly those who are transitioning beneficiaries such
3 as those who have recently moved to an area or switched to
4 Medicare fee-for-service.

5 Medicare beneficiaries, we also found that they
6 had similar access to those that are privately insured age
7 50 to 64. Large surveys show that access was generally
8 stable between 2003 and 2004.

9 We also examined a physician survey regarding the
10 proportion of physicians who are accepting new Medicare
11 patients. In general the most recently available data
12 indicate that most physicians are willing to accept new
13 Medicare beneficiaries. That comes from NAMCS, the national
14 ambulatory medical care survey. Results from that survey
15 show that 96 percent of office-based physicians had open
16 practices in 2004. That is, they accepted some new
17 patients. In 2004, 94 percent of physicians with at least
18 10 percent of their practice revenues coming from Medicare
19 accepted new Medicare patients. These rates are very
20 similar to the ones in 2003, no statistical change.

21 Still reviewing, our claims analysis from Chris
22 Hogan showed that the difference between Medicare and

1 private fees has steadied over the last several years. We
2 saw a slight narrowing in 2004. The analysis is averaged
3 across all types of services and areas. So as you know, the
4 difference between Medicare and private fees varies
5 considerably by type of service and geographic area.

6 Keeping that in mind, research by the Center for
7 Studying Health Systems Change has found that in areas where
8 Medicare fees are closer to private fees beneficiary access
9 wasn't measurably better than in areas where the fee
10 differential is much greater. This suggests that there are
11 other factors such as local health system developments that
12 may influence beneficiary access as much or more than
13 Medicare payment levels.

14 At the last meeting I showed you an analysis of
15 the number of physicians per Medicare beneficiaries. Ray
16 asked that I look at the supply of physicians with caseloads
17 greater than 15, so I'm just showing you here the result of
18 the sensitivity analysis to that effect. The table shows
19 the number of physicians per 1,000 beneficiaries by their
20 Medicare caseload. You can see that on the top column
21 headers. That's the caseload. So the 15 plus is 15 or more
22 Medicare beneficiaries that the physician saw.

1 So in this table you see that the rate increases
2 in all categories between 1999 and 2004. Interestingly,
3 when we looked at the raw numbers behind these ratios we saw
4 two additional findings that I want to mention. First, we
5 saw that a little more than half of the physicians billing
6 Medicare had caseloads of at least 200 Medicare patients,
7 and that the higher the caseload threshold, so when you got
8 to the 200 or more Medicare beneficiaries, the faster the
9 growth rate from 1999 to 2004.

10 MR. HACKBARTH: When you say the faster the growth
11 rate, you're saying the faster the increase in the ratio of
12 physicians to their Medicare population?

13 MS. BOCCUTI: Right. Not necessarily the ratio.
14 We saw the ratio on that slide. What's faster is the
15 number, the growth in the actual number of physicians grew
16 faster the higher their caseload. Does that make sense?

17 MR. HACKBARTH: That should show up in the ratio.
18 So the ratio has increased faster in the 200-plus --

19 MS. BOCCUTI: Right, the ratio grew. They're
20 directly derived from each other so you could say both grew.

21 So then I'll just go on to the second part of the
22 adequacy framework, which is the changes in costs for 2007.

1 The preliminary forecast for input price inflation is an
2 increase of 3.6 percent, as provided in CMS's Medicare
3 Economic Index -- that's the MEI. As you know, within this
4 total CMS sorts the specified inputs into two major
5 categories, physician work and physician practice expense.
6 Physician work, that includes salaries and fringe benefits
7 allotted for physicians which is an expected to increase by
8 3.6 percent. In the physician practice expense category we
9 have non-physician employee compensation, office expenses,
10 drugs and supply, medical equipment and PLI, which is
11 forecast to increase by 8.6 percent.

12 Some physicians, as you know, report PLI premium
13 increases that are much higher than what is forecasted in
14 the MEI. For example, physicians practicing in certain
15 geographic areas such as Detroit and those whose specialty
16 includes high-risk procedures such as neurosurgeons. They
17 report PLI costs that are much higher. But recall, however,
18 that the fee schedule is Medicare's primary tool for
19 capturing this variation. It reimburses services
20 differentially to account for PLI by service and geographic
21 area. The MEI is used as a measure to forecast a change in
22 input costs across all physicians.

1 Lastly on that slide the productivity factor, we
2 also consider that in our input cost analysis. Our analysis
3 of trends and multifactor productivity suggests a goal of
4 0.9 percent.

5 So in sum, the indicators I reviewed today do not
6 suggest a payment adequacy problem for physician services.
7 I'll be happy to take questions and comments.

8 MR. HACKBARTH: Time is short here so I'm going to
9 try to cut to the chase a bit. The way I'm going to try to
10 do that is I'd like to pose to the group a question that I
11 often hear from people on the Hill about this issue.

12 Let me start with a couple points. First of all,
13 we are in the awkward position of trying to think about an
14 update for 2007 when we don't know what the update is going
15 to be for 2006. And making that more difficult is that
16 there's a fairly wide range of possibilities still on the
17 table, so to speak, for 2006, anywhere from a 4.4 percent
18 cut to a 1 percent increase. It just boggles my mind to
19 even think about how you can recommend a number for 2007
20 when you don't know that. So that's point number one.

21 Point number two, and this is getting to what I
22 hear from the Hill and I need help wrestling with. You look

1 at our measures of payment adequacy for physicians and as a
2 group they are more useful in identifying underpayment than
3 overpayment. The one exception, I guess might be the
4 relative price, the comparison of Medicare fees to private
5 fees. But the others focus on access and they're going to
6 give you a sign when payments are too low but not too high.

7 Point number two is that the update
8 recommendations produced by MedPAC using our basic starting
9 point of MEI minus productivity have in recent years
10 produced updates that are consistently, in an aggregate,
11 significantly higher than those that have come out of
12 Congress and the physicians have received. In fact this is
13 the only area I think where that's the case.

14 So what I hear from people involved in this
15 process on the Hill is we've consistently done less than
16 you've recommended yet you tell us that there is no
17 discernible broad negative effect on access. Is MedPAC
18 recommending updates that are too high for physicians,
19 especially in view of the one-dimensional, one-directional
20 measures that you use to set your recommendation?

21 That's a real world question that we get asked and
22 I wanted to present to the group and get some reactions to

1 it.

2 DR. KANE: One thing that struck me is that volume
3 in all the other services we looked at, rising volume meant
4 we were paying adequately. On the physician service side we
5 are now interpreting that rising volume means we're not
6 paying adequately because people are trying to make up for
7 low payment rates with higher volume. Whereas in all the
8 other services we looked at we interpreted volume exactly
9 the reverse.

10 So I'm just wondering if we have a little problem
11 of figuring out what by volume means with respect to access
12 and the payment rate adequacy.

13 MR. HACKBARTH: I think we do and we are not
14 alone. This has been a longtime problem. The fact of the
15 matter is that there are multiple sources. Alan, I think
16 made this point earlier. There are a lot of different
17 forces that affect volume trends, some having to do with
18 medical practice and technology and good services that we
19 want patients to have. Others might be an undesirable
20 response to fee constraint. It's very difficult to
21 characterize these trends in the aggregate.

22 DR. KANE: I think that's the problem. The SGR

1 very clearly says, volume going up is bad and suggests
2 you're -- but we've interpreted that as volume going up
3 means we're not paying enough and therefore they're trying
4 to make up the same income with the volume. Whereas, in all
5 the other services we've looked at we interpret it exactly
6 the opposite. So I'm getting a little confused myself as to
7 what do we mean when we're looking at payment rates. What
8 really makes us think a payment is adequate or not? In
9 physician fees we're saying volume increases means the
10 payment rates are too low.

11 MR. SMITH: Nancy, actually I think we've been
12 speculating and not something slightly more complicated.
13 We've been wondering whether or not physicians think income
14 is too low and therefore have increased volume. But what we
15 haven't used the volume increase as an argument for
16 something other than a cost-based, a cost minus productivity
17 based recommendation. We haven't said, we've got an access
18 problem here that we need to respond to with and out of
19 cycle update. We haven't said that, although some of us
20 have intuited, don't know whether or not correctly or not,
21 that the volume spike has something to do with physicians'
22 belief that income is inadequate regardless of the Medicare

1 fee schedule.

2 Glenn, let me come back to your initial question.

3 There wasn't a recommendation in front of us. It seemed to
4 be entirely appropriate that there shouldn't be. We often
5 feel like we're in a Kabuki play, but making a
6 recommendation for a 2007 fee schedule update without
7 knowing what's going to happen for 2006 would really make us
8 feel like we'd stepped out of a Japanese pageant so I think
9 that makes sense.

10 I get the same question you get a lot. We all do.

11 One of the problems is that it's only definitively
12 answerable if we conduct a natural experiment that we don't
13 want to conduct, which is to figure how far we have to drive
14 payments down before the doctors finally say, no, we won't.
15 We sort of know the answer on the other side of that, that
16 using the MEI, adjusting for productivity, doesn't create a
17 problem.

18 Now maybe we should be taking a look at the MEI.

19 There are ways to think about this without saying, the right
20 thing to do, let's try 3 percent next year and if the
21 doctors still come we'll do 5 percent for 2008. And if they
22 still come we'll push harder. That seems to me a sort of

1 loony path to even contemplate much less --

2 MR. HACKBARTH: That's a straw man sort of thing.

3 Actually what these people are thinking about is not running
4 that experiment on Medicare beneficiaries, but as opposed to
5 2.7, 1.5, which is what they've tended to do. That's the
6 range they're talking about. Nobody's advocating, let's cut
7 the rates by 5 percent and see what happens. That's a straw
8 man.

9 MR. SMITH: But the argument, Glenn, suggests even
10 that if the access data that we use is to be the barometer
11 of adequacy, then you could equally well argue that Congress
12 is overpaying the doctors. We've recommended too much.
13 Congress hasn't followed our recommendations, but
14 nonetheless, they've paid too much because the doctors keep
15 coming.

16 I don't know how you untangle that. I understand
17 that saying we just push them way down is a straw man. But
18 I don't know analytically how you ask yourself, how you come
19 up with a different answer than the question, then let's try
20 to tweak it. Maybe we should try for a while pushing the
21 productivity assumptions up a little bit.

22 But I don't think there's any dispositive answer

1 to the question in the way that you pose it other than
2 running that experiment and seeing what it took.

3 DR. CROSSON: I think it's not surprising that
4 there should be a different relationship between volume and
5 payment for physician services because physicians are, in a
6 semi-unique situation in terms of influence over demand or
7 the volume of services, compared, for example, like
8 hospitals and some other areas of payment.

9 It seems to me that the approach that MedPAC has
10 used traditionally, which is similar to other Medicare
11 services, of looking at the input costs, make sense. It
12 particularly makes sense, or I guess I would say I would be
13 quite averse to seeing physician payments cut by 4.3 percent
14 or whatever is projected, particularly because, as we
15 mentioned earlier, of the differential ability of certain
16 physicians to actually deal with that cut by increasing
17 volume of services in imaging procedures and the other kinds
18 of reactionary sort of things that we've been seeing.
19 That's not spread evenly across physicians and would
20 probably differentially hurt some physicians more than
21 others.
22 Having said that though, I think that going

1 forward the eventual a solution or stabilization of this
2 process is going to depend on coming up with some mechanism
3 within the payment process that does in fact deal with
4 inappropriate increases in volume. That's the sticking
5 point, because the SGR mechanism is a blunderbuss, and
6 ineffective at that.

7 DR. WOLTER: On the issue of our recommendations
8 versus what updates have been occurring, I think there's a
9 terribly unique situation here in that the SGR and how it
10 affects the current budget process is very different for
11 this particular payment silo at this moment in time. So
12 even a negative update puts on paper very, very large,
13 billions of dollars of additional costs that somehow has to
14 be made up, and we don't have that same kind of dynamic
15 going on in the other silos.

16 So my preference would be for us, as best we can,
17 to use the best information we can to recommend the right
18 policy rather than compare what we recommend to this
19 budgetary unique situation that's unfolding. At least
20 that's how I personally would look at it.

21 A couple other comments I have. I don't think we
22 have a good handle on whether or not Medicare reimbursement

1 for physicians is quite adequate. I think the access proxy
2 is one thing. It tells us something, but I'm not sure it
3 tells us enough. Marshfield Clinic and some others have
4 recently done some interesting work on practice expense
5 suggesting that that particular dataset underestimates a
6 practice expense. Maybe that could be expanded and we could
7 look at that.

8 My sense of physician access to capital is that
9 it's minimal, if not close to zero. So if we were to put
10 some information together about that I think we'd find a
11 very different circumstance in the physician world in terms
12 of capital access. So I worry about that, particularly with
13 all the demands that are coming down the pike on physicians
14 for pay for performance and implementation of technology and
15 that sort of thing. So that's just really a caution there.

16 DR. STOWERS: I don't want to state the obvious,
17 but in the presentation we talk about the difference in
18 growth in different specialties. Yet when we get around to
19 talking about the physician update we go back to a blanket
20 number to do that. It just seems we suddenly get
21 inconsistent in that. You wonder if there's not some way,
22 if we're really going after volume, to adjust the update

1 according to the specific areas of physician services that
2 are causing that volume.

3 I know that's been said before so I'm saying it
4 more as a reminder. There are large parts of the industry,
5 including primary care and others, that are very stable in
6 their volume and yet are going to be having an increased
7 cost of business coming on every year, where there's not a
8 volume problem. So it has always bothered me that we start
9 throwing a blanket decrease out there in areas where either
10 the volume is stable or even dropping, or availability of
11 care is dropping.

12 There should be somewhere in our discussion to get
13 more specific that -- and you've said that many times
14 before.

15 DR. NELSON: I think we need to bear in our mind
16 the fact that -- the point wasn't made on the slides but
17 it's in the text, that on average across the country
18 Medicare rates are 80 percent below the prevailing private
19 sector rates; payments. That in the short term we ought to
20 stick with the policy that we've had in the past in
21 recommending an update that would meet the input prices of
22 an efficient provision of services, and replace the SGR with

1 an MEI that's based on that.

2 While we can't specify a number with the
3 uncertainty about what this year update will be, or next
4 year, nonetheless, we can and should continue to articulate
5 that as an underlying premise for our recommendation.

6 But the third point is, in the longer term, the
7 Commission should come to grips with the prospect of
8 fundamental changes in the way physicians are paid, to take
9 into account the need to more adequately pay for
10 coordination of care, and management of care, and
11 prevention, and incorporating higher payments for good
12 quality care than for lousy quality care. Arnie introduced
13 that subject in our previous discussion, but what I think we
14 need to do is come to grips with that as a major effort on
15 the part of the Commission rather than trying to tack that
16 on to our current policies.

17 DR. MILSTEIN: I'd like to reinforce what Alan
18 just said. In particular, Alan referenced something that we
19 have not yet found a way of pursuing, although I think it is
20 doable, and that is to begin to answer the question, what
21 should the update be in reference to what our understanding
22 of what efficient provision of physician services look like.

1 There are examples around the country of physicians, some
2 within Jay's organization and many outside of Jay's
3 organization, that have begun to ask the question, are there
4 ways of substantially improving physician throughput,
5 holding quality and practice pattern efficiency constant?

6 In our recommendations historically we have not
7 yet incorporated the Congressional notion of what kind of an
8 update is needed for the efficient practice of any provider,
9 within any provider group. But I think there are some
10 opportunities within the physician sector, and I don't think
11 between now and next month it's not possible but I'd like to
12 reinforce Alan's notion that if we're going to address this
13 we also examine this question of what an efficient
14 physician, specifically to this provider category, needs in
15 order to deliver high quality services with an efficient
16 practice pattern longitudinally.

17 MR. HACKBARTH: Anyone else?

18 Okay, let us now turn to the public comment
19 period. I am greatly surprised to see Dr. Rich at the
20 microphone.

21 MR. RICH: I promise I'll make my comments brief.
22 I know a lot of you are trying to get to the Northeast where

1 there's a storm going.

2 First of all, I'd like to thank the staff and the
3 commissioners for consideration of my comments last month.
4 I'd like to separate my comments and address the issue of
5 the crisis in primary care that was addressed by Dr.
6 Milstein, Crosson and Ray. There is not a linear relation
7 between valuation, income and manpower. As we found out,
8 manpower is very, very complex when we look at the GMNAC
9 reports.

10 To answer your question, Mr. Chairman, about the
11 devaluation of EM, I had some research done by my staff who
12 -- she was delayed by a storm in Chicago. But if you look
13 at the 150 highest volume codes from 1992 to 1995 the
14 relativity of EM is really maintained. There's only six
15 codes of very low volume and low impact that exceeded the
16 increase in work RVUs for EM. Again, if you go back to Bob
17 Berenson's work at the Urban Institute, total RVU not from
18 2002 to 2004 but from 1992 to 2002 indeed has gone up.

19 So why hasn't the income, and why do we have this
20 crisis in primary care? As. I believe it was Mr. Scanlon
21 pointed out, we cannot increase the productivity and the
22 throughput in a primary care physician's office. So despite

1 the increase in valuation, 36 percent work, if our work
2 recommendations go through, 8 percent move to a single
3 conversion factor, 20 percent practice expenses. We have
4 not seen the increases in income because they are fixed,
5 they are time-based codes with strict evaluation and
6 management guidelines, and family doctors and osteopaths in
7 general cannot increase their throughput.

8 I just finished consulting with Tom Bodenheimer
9 who's a family practitioner at the University of California,
10 San Francisco and he came to the same analysis that I have,
11 that indeed the process with income is due to an decrease in
12 -- the inability to increase productivity. I can do it as
13 an ophthalmologist moving my cataracts from a slow
14 outpatient department in a hospital to an ASC and double my
15 productivity without increasing the rate per 100,000
16 beneficiaries. Ray cannot do that.

17 I'd like to briefly address the specific staff
18 recommendations. The RUC recommendations for
19 representation. Again, it is a Senate type thing. You're
20 not allowed to debate your codes. It's a secret ballot.
21 I'd point out that there's 26 rather than 23 voting members
22 and certainly osteopaths are considered primary care.

1 To address Ms. Burke's comments about what
2 percentage of EM is done by other specialties, and it's
3 actually fairly substantial. OB/GYN is 50 percent, urology
4 34 percent. If you throw in the eye codes, I'm 42 percent.
5 So there a lot of specialties that provide EM.

6 Having said that, both discussions with ACP and
7 with the AMA, there is consideration to add new spots to the
8 RUC and target them for pure cognitive services.

9 Recommendation two, an expert panel, great idea.
10 Again, because frankly, doctors are not going to walk up to
11 the RUC and say, I'm overvalued. I think it's a wonderful
12 mechanism for the five-year review.

13 Automatic review, I agree with all the comments
14 about change in volume and change in site of service.

15 Automatic reductions. As Dr. Reischauer pointed
16 out, there is huge variability in new codes, and we will
17 supply those to you. Some of them do have new technology,
18 or where clinical staff time could be substituted.

19 Currently, starting in 2005, the RUC flags these when they
20 come through as new codes. They don't wait for a five-year
21 review. They are brought back in a time basis, two to three
22 years, to look to see if indeed technology has changed the

1 physician work.

2 Also, we look very carefully at practice expenses.

3 We have a look back provision that CMS has adopted now and I
4 think that's actually a huge area that's been overlooked.

5 But we have a volume or a dollar amount of devices or cost
6 of equipment that automatically triggers a review in, I
7 think it's two to three years. I'm not sure.

8 Recommendation five, mandated periodic review.

9 Good idea, but as some pointed out, huge resources are
10 needed. We've already reviewed 85 percent of the codes, the
11 codes that provide 85 percent of Medicare expenditures. The
12 remaining ones are very, very low volume, 200 cases a year,
13 50 cases a year. I think there has to be some thought given
14 into expanding that and looking at the work entailed.

15 Again, thank you for the time.

16 MR. REGAN: Mr. Chairman, my name is Jim Regan. I
17 was here last month. This is my second visit in a row.
18 It's not that far for me. Fortunately, I only have to come
19 from Georgetown so even in the snow it's not too bad. I'm a
20 practicing urologist at an academic medical center. I'm a
21 member of the RUC. I've been a member of the PEAC almost
22 from the beginning. I'm chairman of the American Urologic

1 Association's Health Policy Council.

2 In the two meetings that I've been here I've been
3 struck just a little bit about the fact that primary care
4 for some reason seems to be a sacred cow. Of course, I need
5 primary care physicians and my patients need primary care
6 physicians and I don't mean to denigrate them in any way.
7 But I would like you also when you address manpower issues
8 or you think about that, think also about, for instance, my
9 specialty, urology.

10 My mother, my primary care colleagues all seem to
11 say, oh, you're a urologist. But my response always is,
12 yes, but sooner or later we're going to get you. And that's
13 true with our aging Medicare population. We project maybe a
14 shortage of as many as 2,000 urologists by the year 2020, so
15 I just wanted to speak to that.

16 The second thing I wanted to mention is to address
17 what Bill had said, that not only do primary care physicians
18 do E&M services and submit bills for that, so it's wrong to
19 think, as we all are guilty of, of saying, E&M equals
20 primary care. That's not always the case. Nor is it the
21 case to assume that cognitive physicians do not do
22 procedures or do not bill for tests or imaging. That also

1 is happening as well.

2 The third thing and final thing is, along those
3 same lines, I think it's wrong to carve out E&M for primary
4 care and assume that their E&M is somehow more valuable than
5 my E&M. As urologist I give longitudinal care also.

6 I would just like to thank you for your time.

7 MS. MCILRATH: Sharon McIlrath with the AMA. I
8 just wanted to make an observation about the findings that
9 you had on the quality MACIES and to just note that that
10 causes a problem with the SGR, because as you found, more
11 things were done in the physician side. Yes, that did you
12 create savings over on the hospital side. But in the silo
13 mentality that we have, physicians are going to be penalized
14 for that.

15 I also wanted to point out that on the billing
16 numbers, I don't know if this is actually reflected in there
17 or not, but there were some changes. CMS was encouraging
18 people to go to individual billing as opposed to billing
19 through a clinic number. You may want to look at that and
20 see if that has any effect.

21 Finally, I just wanted to say with regard to the
22 Secretary and the suggestions that the AMA provided, we

1 provided them with a list of 45 things that was collected
2 from the specialties on things that they thought were
3 contributing to volume increase. CMS looked at four or five
4 of those. They did not look at things such as the impact
5 that practice parameters, quality measurement, was having on
6 the volume of physician services.

7 So one of the things that in fact you have
8 identified in this report they did not pay any attention to.
9 So I do not think that their assessment -- not that the list
10 was ever intended to say this is a complete explanation.
11 But I do not think that their particular review was very
12 comprehensive.

13 MR. HACKBARTH: Okay, thank you and we'll see you
14 in January.

15 [Whereupon, at 11:49 a.m., the meeting was
16 adjourned.]

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