MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Wednesday, January 14, 2004
10:19 a.m.

COMMISSIONERS PRESENT:

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

AGENDA ITEM:

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

MR. ASHBY: Good afternoon. This is the hospital session. I'm going to begin this session by presenting overall Medicare margin data which support our assessment of payment adequacy for the hospital as a whole. Extending beyond the data that we presented in December, this time we'll be including information on margins by hospital group and data on the distribution of margins. Then Julian will address payment adequacy as well as our draft update recommendation for inpatient services, David will briefly update our information on access to capital, and Chantal will present outpatient margin information and our outpatient update recommendation.

This first chart shows overall Medicare margins for 2000 to 2002, and our estimate for 2004 which reflects policy changes that occurred between 2002 and 2004, and also the impact of policy provisions in DIMA, or MMA, if you prefer, that were scheduled for implementation in either '04 or '05. You'll notice that the margin estimate for 2004 is 1.8 percent while the estimate that we reported to you in December with 2.8 percent. Unfortunately, most of this change resulted from a mistake that we made. The mistake didn't affect any of the six component margins. Rather, it involved the process that we use for weighting the six component margins to arrive at the overall Medicare. We apologize for the error.

In addition to our mistake we also discovered a problem in CMS's cost report file. We corrected for the bad data through imputing and that lowered our estimate of the outpatient margin that we presented in December, and Chantal will, a little later, give you the details on that.

Now onto the values. We see in this chart, obviously, that we have a small reduction in margin in '01, a larger reduction is '02 and essentially no change to '04. Unusually large cost increases were instrumental in both the '01 and the '02 decreases in margin, but in '01 the cost increase was offset somewhat by an increase in DSH payments that was mandated by BIPA and a large increase in outpatient payments that followed the implementation of the outpatient PPS.

After '02, the almost constant margin represents the net effects of a substantial increase in payments from a number of DIMA provisions and CMS's tightening of inpatient outlier payments. Excessive outlier payments pushed total inpatient payments nearly 2 percent higher than was intended in 2002. Our simulation for '04 assumes that the system reforms that CMS implemented will return aggregate outlier payments to the targeted level. It's quite possible that within that time frame outliers will not drop all the way back to the target level, in which case the margin estimate that we have shown would, all else equal, be too low.

At the December meeting we provided the estimate that Medicare inpatient cost per discharge rose by 6.6 percent in 2001. That was the highest increase that we have seen since the early '90s. But we wanted to point out that the increase in cost per unit of output across all services that hospitals provide is somewhat lower.

Our all-service measure that you see here known as cost per adjusted discharge shows a 5.0 percent increase. This calculation is for all payers. Data limitations prevent us from putting together a measure specific to Medicare but we do at least have strong evidence that the Medicare figure is substantially less than the 6.6 for inpatient alone. For 2002, again our preliminary data show that the rate of increase is lower when calculated for all services than for inpatient alone.

The next chart summarizes some of the key factors causing the unusually large rate of growth in per-unit costs. In this analysis we're looking at all costs. That is for all services across all payers. We found a major impact from increased labor costs, including both increases in wages and benefits and increases in use of labor, and that the increases were concentrated particularly in the area of nursing personnel. But as we talked about in December there is already evidence that the rate of growth in labor cost is abating. BLS data show that hospital wage and benefit increases peaked at about 5.5 percent in 2002 and that increase was down to about 4 percent by the third quarter of 2003. That's actual data through the third quarter of 2003.

Similarly, hospital employment increases peaked in 2002 at about 2.8 percent and they were down to about 2 percent by the third quarter of 2003. Then we had smaller impacts from drugs and chargeable supplies, and that would include devices, malpractice costs and capital expenses. On the drug issue, the rate of interest in overall drug spending has moderated somewhat in '03 but we're not really sure how that played out for drugs provided in the course of hospital care. Malpractice costs tend to be very cyclical, so the unusually high rate of growth that we saw in 2002 is bound to moderate at some point in time.

The rate of capital cost growth on the other hand may very well rise in 2003 and beyond given the ample evidence that we have expanded capital investment. But Medicare capital payments are not intended to draft new capital investment year to year. Given the capital cycle, hospitals should expect lower margins for a certain period of time following a major capital project, and all else equal they would receive higher margins in the later part of the capital cycle.

The third factor is reduced financial pressure from private payers. We have ample evidence that private insurer payments have gone up faster than costs in each of the last three years and that the increase was particularly great in 2002, the year of the high cost increases. This factor may have enabled higher cost growth, higher growth in unit costs than otherwise would have occurred.

The next chart focuses on changes in margin between 2002 and 2004 by hospital group. Again, the 2004 figure reflects the

provisions of DIMA as if they had been in place in 2004 and also changes in policy occurring between '02 and '04. I need to begin here by noting that we couldn't model two of the provisions of DIMA at the group level so all of the group-level margins in this table are understated by an average of about 0.4 percent. The two provisions in question here are a one-time opportunity for hospitals to appeal their wage indexes, which CBO has estimated will bring $300 million into the payment system, and also liberalize payment policy for critical access hospitals.

There are 234 hospitals that our simulation suggests would still have negative overall Medicare margins after accounting for the provisions of DIMA and that could otherwise meet the qualification criteria for CAH, so we modeled the impact of these facilities leaving the PPS. The right-hand column though shows that two groups in particular, the overlapping rural and non-teaching hospital groups would likely receive most of the benefit from these two provisions.

Now as for the changes by group, the drop in margins for urban hospitals primarily reflects the impact of tightened outlier payments together with a modest increase in payment from DIMA. Rural hospitals, on the other hand, benefit tremendously from DIMA, as was intended, but they receive little outlier payments so they were not affected much by the tightening of outlier policy.

Then major teaching hospitals, again, their drop in margin primarily reflects tightened outlier payments, and that brings us to the non-teaching hospital group. Of course, this group includes almost all of the rural hospitals whose payment increases were substantial under DIMA, but urban non-teaching hospitals account for about 70 percent of the payments in this group. Urban non-teaching hospitals benefit from some of the DIMA provisions but then, as in the future under current policy, they receive none of the IME payments above the empirical level and their DSH payments are below average as well.

On the distribution of margins, in 2004 and reflecting the impact of DIMA provisions, we estimate that about 50 percent of hospitals will have a negative margin. And using the weighted measure, that is the percent of payments that go to negative margin hospitals, the figure would be about 46 percent.

MS. BURKE: Could you repeat that?

MR. ASHBY: This is 2004 reflecting the impact of the DIMA provisions. At that point we estimate that 50 percent of the hospitals would have a negative margin, but if we did it on a weighted basis, 46 percent.

MS. BURKE: I guess I'm trying to equate that number with the numbers that we see before us and I just want to make sure I understand. These are the margins by type of hospital?

MR. ASHBY: Right, these are aggregate margins for the hospitals in each group.

MS. BURKE: And overall it has an estimate of 1.8.

MR. ASHBY: Right.

MS. BURKE: What you're suggesting is, if you were to dial that down, that half the hospitals would be negative.

MR. ASHBY: Right. And within each group it's worth noting

that there's quite a wide variance and a significant portion of negative margin hospitals in every one of these groups.

MS. BURKE: The other question that I would have, given the discussions around the nature of the non-teaching hospital and what we now understand in terms of what this distribution is going to look like in terms of margins, is there value -- and I'm prepared to have somebody say it doesn't make any sense because we don't do it any place else -- is there value in looking more carefully at that category, and for example, splitting out urban non-teaching versus rural non-teaching? We have those as separate categories. But because that is the one place where there are margins that are overall negative is there a value in splitting out what that looks like?

MR. ASHBY: There certainly would be. We have now looked at non-teaching separately for urban and rural since the impacts are quite different. The rural non-teaching, the margin would be very close to what you see for rural, because almost all rural hospitals are non-teaching. The urban non-teaching margin would be minus 3.1.

MR. MULLER: We discussed this last month but what inflators were you for using for 2002 to 2004? You made the point in your presentation earlier that -- you had the 6.6 and the 5 percent, the 6.6 for inpatient and 5.5 for overall. But what are you using to go from 2002 to 2004 to get to your '04 estimate?

MR. ASHBY: We're using market basket minus half of the productivity standard.

MR. MULLER: So roughly around three.

MR. ASHBY: Roughly in the neighborhood of three.

MR. MULLER: So if it's in the five range, then the 1.8 could be an overestimate. I mean, by definition it would be an overestimate.

MR. ASHBY: Yes, pretty much, by definition, right.

MR. MULLER: As I think we discussed it -- I don't want to go through the whole thing again as we did last month, but at last for probably '03 we can all see next year where we come out on these things but my guess it's going to be closer to five than three, so that could throw even more of the hospitals into negativity if the 1.8 --

MR. ASHBY: But keep in mind that we have a 5 percent figure approximately in 2001 and with the evidence that the rate of growth has come down I'm not sure that we will be much off of three. We might to some degree. There is indeed some risk here; there's some uncertainty. But there's also uncertainty on the payment side. It's quite conceivable that the outlier impact, we have assumed that all extra outlier payments go away, and we're not at all sure that that's really going to happen. And some of the DIMA provisions -- again, we're not exactly sure how those are going to play out, so there's a great deal of uncertainty here but it's not entirely clear that it's going to be higher, much higher than what we've shown.

DR. WAKEFIELD: Jack, when I'm looking at the estimated '04 rural, a little bit to Sheila's point earlier, and the non-teaching category of minus 1.6 and trying to get as clear a fix on what that category of non-teaching looks like since it seems

to be doing the poorest here of all the different categories, Sheila was asking about might there be difference by rural-urban, for example, and you said, yes, the urban non-teaching probably are minus 3.1 and the rural non-teaching is going to be a lot closer to 2.3. That 2.3 includes CAHs in it; is that correct?

MR. ASHBY: No, it does not.

DR. WAKEFIELD: So it's non-CAH --

MR. ASHBY: This entire analysis is non-CAH.

DR. WAKEFIELD: Not just the '04 CAH, which is what your asterisk says.

MR. ASHBY: Exactly. All of the figures are exclusive of CAHs that we knew about at the time of the analysis which is 835.

DR. WAKEFIELD: My apologies. I misread your asterisk, because it mentions DIMA so I thought everything prior to DIMA CAH would be included. But you're saying no.

MR. ASHBY: Exactly.

MR. MULLER: The estimate we had for 2002 last year, do you happen to remember --the 1.7 we're showing now -- do you remember what we estimated for 2002 at this time last year?

MR. ASHBY: We estimated 3.9 percent for 2003 last year. That's what we were estimating at the time. We didn't have an estimate for 2002.

MR. MULLER: So we did make a gap estimate?

MR. ASHBY: No. As we don't have an estimate for --

MR. MULLER: I understand that. But in a sense you must make one because --

MR. ASHBY: No, actually we don't. It's far easier not to estimate the middle one because then you don't have to analyze things that went in and came back out and so forth. You can just look at one set of policies.

MR. PETTENGILL: The information that Jack has just given you is relevant to two important questions. One is whether Medicare's current aggregate payments are sufficient to cover hospitals' cost of furnishing care to Medicare beneficiaries. The other question is whether those payments cover costs consistently across hospitals.

As you think about these questions though, it's important to take into account the evidence that we presented back in December on the other indicators that we use in the payment adequacy framework, and those are shown on this slide here. To briefly recap the findings, first, we found no evidence of any deterioration in beneficiaries' access to care based on providers participation in the Medicare program, on changes in their capacity to furnish services, or on beneficiaries' use rates.

Second, the volume of inpatient and outpatient care has continued to grow. No evidence there.

Third, we saw mixed evidence on the quality of care with some improvements but also some important problems remaining. However, there's no discernible connection between Medicare's payment rates and either the improvements in quality or the problems that we identified. So that evidence really doesn't tell us very much.

Available information also suggests that access to capital remains adequate although the cost of capital varies among

hospitals. Now since the December meeting some additional reports on hospitals' creditworthiness and access to capital have come out and those reports have led some people to suggest that access to capital has been deteriorating or is about to. We've been looking into that and David is now going to summarize our findings.

MR. GLASS: Thanks, Julian. This is just a quick update to what we talked about in December. We mentioned then that construction spending was strong and here's some quantification of what that means. It means a 20 percent increase from 2001 to 2002 and 11 percent from 2002 to 2003. Or in dollars terms we're talking about going from about $12.9 billion in 2000 to $18.5 billion in 2003. So the strong growth seems to represent some real confidence in the sector in the capital markets.

That's not to say that every hospital has terrific access to capital or is spending at this rate. As one of the analysts pointed out, there are hospitals that have weak market positions, that have major management problems, and have uncontrolled costs. They may have a problem accessing capital but changing Medicare payment rules probably won't fix it.

Now the other question is, is capital spending sufficient to replace depreciating assets, even though we can see that as very strong? There was recently a report by HFMA that looked at this question and they compared the acquisition of fixed assets, buildings and fixtures and major movable equipment, to reported depreciation and amortization expenses for Medicare cost reports over five years from '97 to 2001. They were concerned that 40 percent of the hospitals had an index value using that formulation of less than one.

But these individual hospital numbers may not be very informative. For example, it really depends on where the hospitals are in the construction cycle. A hospital that was new in 1996 would have extremely high depreciation expenses and presumably very low acquisition costs for the next couple of years. So it would have a low index value but it would be a brand new hospital. So they may very well have been modernizing it at least the appropriate rate, and it certainly didn't lack access to capital.

Conversely, an old hospital with low depreciation expenses might spend a lot on fixing the roof and that sort of thing and have a high index but not be in particularly good shape. So the individual values for this index that they introduced may not be particularly informative.

But using the data in that report we found that in aggregate the index was 2.2. Because the update is concerned with the level of aggregate level of dollars in the system, that would seem to be a better indicator for capital access and spending. It would say that it's over twice the depreciating assets. That's it for access to capital.

MR. PETTENGILL: Now taking the margin estimate and the information you've just heard about the other factors, the other indicators, we believe that suggests that in the aggregate Medicare's payments remain adequate in fiscal year 2004.

That brings us to the second stage of the update framework.

As shown on this slide, this update will apply to Medicare's inpatient operating payment rates. Given that aggregate payments are currently adequate, the issue is how much efficient hospitals' inpatient operating costs should increase in 2005, not counting any changes in volume or case mix which the payment system adjusts for automatically? Under current law the update is set equal to the projected increase in the market basket index. There's also a provision that provides for a 0.4 percent reduction for hospitals that fail to furnish quality data.

Now the update framework provides a useful guide for developing a recommendation because it takes into account whether payments are currently adequate, projected in changes in input prices, our policy goal for productivity gains, and our allowance for the effects of cost-increasing but quality-enhancing new technologies.

However, at the end of the day the update recommendation is a judgment that you have to make every year. It is informed by the update framework but not dictated by it. This year we're facing a lot of uncertainty as a number of people have noted, Jack and others, and it's not clear how much efficient providers' costs will have to increase in 2005 because that will depend on what happens to labor costs, what happens to costs for drugs and supplies, and malpractice and capital.

Similarly, it's not clear what will happen with payment growth. There's a lot of uncertainty there regarding the outlier policy, as Jack mentioned, and also about the impact of a number of provisions added by the new legislation, some of which are particularly uncertain and we've mentioned most of those: the wage index reclassification, particularly the one-time reclass, what happens to critical access hospitals, how many further hospitals drop out and obtain critical access status, and also payments for new technologies.

Given that, we're taking that into account in offering the draft recommendation that is now shown on the screen. We believe that a reasonable judgment might be that efficient providers' costs will increase by the full rate of increase in the market basket index. Although we still expect efficient providers to make productivity gains, the judgment is that there may still be strong cost pressures operating that would be sufficient to overwhelm at least a part of that and, thus, a prudent course of action would be to recommend a somewhat higher than usual update that would be suggested by the framework. That's reflected the draft recommendation.

Now because it's consist with current law there would be no spending implications, nor any implications for beneficiaries and providers. That's that.

DR. ROWE: Can I ask a general question about -- whenever we go through this we always hear from the industry, and I'm sure it's accurate, yes, the average hospital did so-and-so but their Avogadro's number of hospital that did very badly or are on the brink of suffocation, which may be true. I believe it. You give us numbers which are mean numbers and you talk about adequacy in the aggregate, is the term you use, in terms of access to capital, in terms of X or Y or Z. I think this is just worth a

minute or to of conversation because I think everybody's right. These data are right, but the concerns about the vulnerable institutions are valid also, and not all hospitals are the same.

MR. HACKBARTH: I think you may have been out, Jack, when they reported some information about the distribution of winners and losers. Do you want to just quickly --

DR. ROWE: I'm familiar with -- I didn't hear this. I was out. I apologize. But I've seen the distribution. I guess my question is, what is our policy? What is the relevant data that we make our decisions on? Is it the mean, the median, the standard deviation, one standard deviation below the mean? In other words, is there some way that we can act in order to take into account the variation?

MR. HACKBARTH: I'll do the general version and then let them do the more technical version. We focus in the first instance on the average margin. But in recent years I think we've paid in fact particular attention to the distribution and who is losing and why. At least the last couple years when I've testified on the Commission's report we've gone through this with members of Congress and the basic point I've tried to convey to them is that increasing the update for all hospitals is an inefficient tool for dealing with problems particular to certain types of institutions. We are far better off trying to identify why particular institutions are, as a class, losing money and addressing those issues specifically as opposed to just increasing the update for everybody.

So that was the philosophy, the way of thinking that was, for example, behind our rural recommendations in the June 2001 report. We concluded, based on analysis, that in a variety of different ways rural hospitals were not being treated fairly, if you will, by the system and made recommendations to fix those problems.

So I think our record is one of looking at both the average and looking at the distribution and trying to target solutions where there are identifiable problems.

DR. ROWE: I'm with you 100 percent but then when we get to the recommendations it doesn't reflect anything about that. Now it may be that the distribution currently is not one that meets yours or ours or the staff's or anyone's threshold for doing further analysis, singling out a particular group as it was with rural in the example you give.

MR. HACKBARTH: I think that as some of the questions have already have indicated it would be worthwhile to look at the non-teaching category some more and try to understand what is going on there. I want to be clear though that this is not a results-oriented analysis. I don't think we want to fall into the trap of saying, this category has a negative margin, therefore we ought to just increase payments to them. What we did in the case of rural hospitals was analytically look at how the system adjusted for various factors and conclude that they were inappropriately, unfairly being hurt. It wasn't just that they were losing money. The system wasn't sufficiently refined to deal with their unique characteristics.

So we don't want to just create a new non-teaching category

that has a special update factor, a special payment adjustment just because they lose money. That would be a mistake in my view.

DR. ROWE: One final question on this, and I find this helpful and I hope others do, is when we look at an individual subset or subsets of a population of doctors or hospitals or nursing homes or SNFs or whatever and we see that they're disadvantaged, not that just their results are underwater but that they're disadvantaged because of whatever, then do we have a policy with respect to the budget neutrality or not of recommendations we make with respect to fixes for that set of institutions?

MR. HACKBARTH: I think we've addressed those issues on the merits and individual cases. For example, if it's an issue regarding the accuracy, the appropriateness of the wage index. inherently we're talking about an index that has relative values, so we tended to say those should be budget neutral changes and not new money. But there are other instances, for example, the DSH payments, where we made a recommendation for new money to be added to the DSH formula for rural hospitals.

DR. REISCHAUER: To the extent that the aggregate margin seems to be more than adequate, then the fix would likely be one that was budget neutral at least.

DR. ROWE: I just think it's worth reviewing a little since we're faced with this distribution issue.

DR. REISCHAUER: But there is this distribution issue which is, what if the 10 largest hospitals in the United States had, or the 50 largest had margins of 3,000 percent and everybody else was negative, would you be happy? No.

MS. BURKE: A couple of questions and then just a concern. Julian, I want to understand -- actually, let me state the concern at outset. I think one of our challenges this year in the overall presentation in the report will be some framework that allows people to understand why we would look at the response in each sector somewhat different. In some cases we did market basket, in some cases we did market basket minus productivity, in some cases we did something else. That issue occurs to me particularly when you look at this, and actually Nick raised it a little bit in the context of how do you segregate out SNFs or home health from the broader question -- in the context of productivity.

In each of the prior discussions the presumption is that productivity, that there is an adjustment for productivity that is relatively uniform across the sector. We come to hospitals and in fact, as I understand the recommendation, we make no adjustment for productivity. That is one piece of this broader concern of mine that we are going to have to explain to folks who will look at this and say, why in this case did they decide that because there is uncertainty -- I mean, I think a lot of the conversation here has been quite helpful, but there is uncertainty in everything. There's nothing certain about anything that we've talked about all morning.

So every other sector is going to be equally as confused about a lot of the changes that are coming into play and a lot of

the other dynamics. So I think it's going to be incumbent upon us to help people understand why this in fact is different, why the recommendation here doesn't have a productivity adjustment.

MR. MULLER: I heard Glenn say that if you have a margin of 15 it's okay and if you have a margin of 1.8 then -- I mean, if you have a margin of 15 then there's some room.

MS. BURKE: But what concerns me is not just about the margin. That would be the natural presumption, here's a margin of X so you can take this. There's no magic margin number as far as I can tell, and I think looking in from the outside, we have the benefit of enormous conversation and tremendous input by the staff, but when you look at it free of that I think it is incumbent upon us to give people some sense of it's not just the margin. It is a whole series of considerations that have to be taken into play when we look at these things. But this one will look odd in some respects as compared to the others, particularly around productivity in the broader question.

So I just think as we think about how we say this, whether it's in the introductory document, whether it's in the language we use in each of these sectors, I think we have to be very careful that we don't confuse people further, and that the natural presumption will be, if the margin is X then the answer is Y. Because it's not that directly related. It's a broader context I think.

MR. HACKBARTH: Let me just make a couple of quick comments and then I'll let some other commissioners jump in. Here's my thinking on it.

First of all, I want to be clear that the fact that the recommendation is for a market basket for hospitals this year, people should not read too much into that. They should not read into it that this means that hospitals will not ever -- forever more be subject to a productivity adjustment. The reason that I feel like this appropriate this year, or several reasons actually, one is that we've seen a fairly significant decline in the average margin to a level that is low compared to other sectors.

Second, there is I think always uncertainty, but maybe a little bit more uncertainty than usual in this case about both the cost and payment trends, for all the reasons that Jack has described.

Third, in the case of this sector we have a distribution of margins that has a fairly high number of institutions with negative margins. Frankly, that was a bit of a surprise to me. I had anticipated that as a result of the reform legislation that we might see a reduction in the number with negative margins, but we have not.

So for those factors in combination, which I think are unique to this sector, I think it's a prudent step to go with a market basket increase this year for both the inpatient and outpatient hospital services. But again, I don't think it necessarily means that we won't be back next year saying that there should be a productivity adjustment.

MS. BURKE: I have no confusion about the fact that each of these decisions is unique to this year and each year is a

different year. I in fact am fully supportive of this recommendation. So this is not because I'm concerned about what's being proposed. I think it makes perfect sense.

It is really about helping people that don't have the benefit of this conversation to understand why there is consistency in what appears to be an inconsistent set of decisions. Why in fact it makes perfect sense for exactly the reasons you suggest. I think it is simply incumbent upon us -- I think we presume that people know or understand perhaps more than perhaps they do when they read what it is that we've said. I think this year particularly we have to be careful about creating the right understanding of what our intentions are and why we got where we got. It's just the one further step to explain the decisions. But I am perfectly comfortable with the decision that's been proposed.

MR. SMITH: Let me follow up on Sheila in a slightly different direction. I have a hard time reconciling the data that Julian summarized on the seventh slide with the recommendation. It is partly, I think, and something we've talked about before of whether or not the Medicare margin data tells us less than we think it does. We implicitly here, and I think this was what was troubling Sheila, while we having targeted margins in any sector we clearly have concluded that there's some level of margin that's acceptable and when you get below it we begin to get nervous, and in this case our nervousness is reflected in not applying the productivity adjustment to the inpatient and outpatient update that we've applied in other sectors.

If Julian's summary of the access, quality, service volume data, that ought to tell us there's nothing obvious to worry about here. There is uncertainty, but there's not something going on on either the beneficiaries' access to care or the quality side which suggests that prices are wildly out of line. Instead we've fallen back on this unstated assumption that there is some level of Medicare margin that is too low. It's unstated because we don't have the vaguest idea what that is. This is instinct. I don't think that works.

The other question -- people are tired of me raising it so I'll do it briefly -- is it does make me wonder whether or not the Medicare margin is a useful proxy for anything else that we care about. We start out, correctly I think, suggesting that what we care about is access and quality. This recommendation doesn't flow from what we know about either of those two propositions. That's troubling and I think it's a different way of describing what was troubling Sheila.

MR. HACKBARTH: Dave, what recommendation would flow?

MR. SMITH: I don't know, and it's the reason I will support this recommendation. But I do think it's an agenda that has got to get higher on our plate, is trying to figure out the rationale, or conclude that there is no rationale, why we so focus on Medicare margin as a proxy, apparently focus on Medicare margin as a proxy for quality and access even when the quality and access data that we have different doesn't suggest that these two are moving in sync at all.

DR. REISCHAUER: Just a the comment on that, David, and that is that I think the margin information is actually the canary in the coal mine. By the time you get to be able to measure an access problem you are in freefall, I think, and probably the same is true for quality.

MR. MULLER: I totally agree with Bob's summary there because what happens in terms of access and so forth is then people really do know their direct costs versus their total costs and keep services going if it covers direct costs. They don't necessarily reduce those as quickly as a total margin calculation might suggest. And certainly in terms of quality, all the discussion we've had, at least the years I've been on, is how hard it is to measure in the first place. So the notion that if it's hard to measure in the first place you can somehow capture changes in it quite quickly is hard to conclude. So in that sense, since we're measuring a very difficult area we shouldn't be able to capture differences in a very difficult area that quickly.

We even, as we've discussed with our three-year lag in cost data, we have enough anxiety about that at times as to how one runs that forward from a three-year old base each time. So I think there's good reason, as Bob has suggested, to worry about our ability to capture access and quality very quickly. At the same time I agree with David's point, it's an evolving field. Obviously if one has spent 50 years trying to get cost reports to work, one can't assume that access and data can be nurtured and made mature in a five to 10-year period. I think it's going to take a while -- maybe not 50 years but it's going to take a while to have the quality information that's really only been focused on I'd say in a four to six-year period to be anywhere near the level we want it to be.

DR. WOLTER: The comment that the overall margins are adequate in aggregate I just think over time needs a little clarification, because is 1.8 percent adequate in aggregate? Is 1.5, is 2.0? I don't know what the right number is and I know we don't have that fleshed out here. But I worry about it because we would then either be targeting to get everybody to 1.8 percent in these subsectors perhaps and feel that that's okay or something else. I'm really not sure what the policy implications of that are because we're obviously concerned that there are institutions within this aggregate 1.8 percent, half of them, who have negative margins that seems to be influencing our decision on the productivity factor this year. So it's just a question that I wonder where we might go with over time.

I'm also concerned as we've had this discussion that pops up through the day that the inpatient margins look, relatively speaking, better than the outpatient margins. I do have some concern that the current outpatient system may not have the right base set point for overall aggregate coverage relative to inpatient. I think the update recommendations here are fine because they're aimed at both, but again, over time are we going to try to have the APC system on average cover the cost of an efficient provider or not? And we may not be able to trust this margin data, outpatient versus inpatient. But I think at some

point we might want to clarify where we want to take that discussion.

Then lastly, in the recent legislation 0.4 percent of the inpatient update is tied to the quality reporting. I think we have been in other sectors trying to create encouragement around linking some payment incentive to quality. This may not be the year to try to do that in the fee-for-service inpatient and outpatient side but I wonder if we should at least have some comments in this section that we do encourage, as time unfolds, looking at mechanisms to link quality reporting and measures to payment.

DR. NEWHOUSE: I want to underscore what Sheila said in that I think the chapter needs to have a statement that we're not abandoning our framework and have some explicit reference to both productivity and S&TA and then basically go on with the response that you, Glenn, gave to Sheila as to a judgment call about what is going to be an adequate pot for 2004. Explicitly margins are in that mix, because that was your first point, and in fact your third point was the distribution of margins. But we wind up saying it's a judgment call.

On Nick's point, if we're going to say how adequate is the APC, I would prefer, as I said before, that we compare that against the direct cost of the outpatient department on the assumption that, as I said before, that the joint cost will get picked up in the overall Medicare margin in any event.

DR. ROWE: A couple comments about margins. Over the course of several years here I think the most important piece of progress we've made in this has been going to the most-of-Medicare margin as opposed to the inpatient Medicare margin which is what we were focusing on some years ago because of cost allocation issues, and because of adverse incentives to put activities in one place versus another, and because of the evolution of medicine and the importance of outpatient. So I feel while this is maybe not satisfactory it's a lot better than where we were I think from my point of view.

I think some comments about the margin is 1.8 or whatever it is, what does that tell you? What's the difference how low it is, what does it tell us about what we really need to know? If we take that approach I think we should be disinterested. That is, I think we would have to say that there is no margin that's too high as well as no margin that's too low, and I don't think that's what I here. What I hear is when the margins are high, they're too high. And when the margins are low, it's what does this really tell us? So I think we need to be careful about that.

What it really tells us, whether it's too high or too low is obviously related to what proportion of the revenues of the organism or organization are related to Medicare. So it might be very different at different entities.

I wanted to emphasize that I think the margins are interesting if for no other reason to watch the trend of them over time. Maybe not to make the individual annual decision based on them as we're urged to do when they're low and we're urged to neglect them when they're high. But to look at the

trends over time. I thin that does tell you something about what's going on in the sector and I think it tells you something about my favorite hobbyhorse, which is access to capital.

So if we were not going to use them to make any decisions -- it's kind of like a PSA level. Any one number isn't that helpful. You have to have several years of PSA levels before you can tell a patient whether or not his PSA is going in the wrong direction or not. So I do think from a trend point of view they have some intrinsic value although I would agree that we shouldn't overly rely on them.

The other thing I would say lastly is that, in addition to being concerned about the variance, my concern about the variance with this particular group or the new group of losers, these non-teaching hospitals, is that the median number -- and this is a reprise of some earlier conversations -- the median margin number is moved to the left front rather than to the right. I wouldn't be so concerned if the variance was still great but it had moved to the right, other than maybe we need to reduce payments. But if it's moved to the left and there's still variability, then I think that's the instance in which we should put a microscope on the lower end and really analyze it to see if there is some intrinsic deficit in the way we're treating them.

MR. HACKBARTH: I think that's an excellent point. Allen Feezor, Alan Nelson, and Ralph and then we need to move on to the outpatient presentation.

MR. FEEZOR: I was going to reinforce Joe's comment about we do need to make explicit the retention of our policy with respect to productivity and the like. Then Jack took my other comment about that we need to -- I think it is incumbent upon us to begin to try to establish correlation between margin and access. That's access both to care and to capital and I think begin to monitor that more, or look at that more in that perspective.

Then the final thing I guess, in this next round of applications for clinical access hospitals I would like, if we could, to track the concentration or the growth in concentration of for-profit hospitals in that particular sector.

DR. NELSON: I'm uncomfortable with our apparent inconsistency here. Elsewhere in our report we're going to explain and justify why we believe productivity should be applied to these other segments. So I'm uncomfortable then with us plugging in productivity one year and not another year based on what the circumstances are. It seem to me we ought to try and have a uniform approach that we apply as broadly as we can and as consistently from year to year, and we do. The first question we say, are payments adequate currently, or are Medicare payments in 2004 adequate?

If indeed we undershot and margins are lower than they are because we miscalculated on what the costs were going to be then we ought to say, and we ought to have a 1 percent get-well factor. We ought to say it's because we undershot. Then we ought to go ahead and apply a carefully calculated market basket with productivity as we do for the other Medicare portions. I'd be much more comfortable with that rather than for us to just sort of fudge it.

MR. MULLER: Alan has expressed what I feel as well because we have the framework of payment adequacy plus update in a variety of areas today and in other years when we have margins of 10, 12, 15 percent in SNFs, et cetera, and so forth we say, payments adequate and we probably don't need an update and we vote not to give updates. In an area here where there's, I think some could argue that 1.8 is not adequate we've, in a sense, taken the -- as Alan has said, we've basically taken the productivity and used that as a way of dealing with the adequacy issue. In other words, instead of saying, let's make them adequate and then you can do the update minus productivity.

Now I agree with the recommendation that was made. In a sense we've kind of backed our way into it. But in terms of the framework that we have, if we're going to maintain that kind of adequacy plus update framework then at some point we need to say when are margins inadequate? In a sense, the DIMA has done that with a bunch of add-ons in the specific areas that you talked to earlier, the rurals and making more critical access hospitals and so forth. That's another way of saying that the payments there were inadequate and therefore they'll get more than updates because -- I can't remember now what the increases were, Jack. It was 6, 7 percent whatever came in DIMA, for the rurals. It's probably more than 6 or 7 percent. In a sense they had a -- that was an explicit judgment about adequacy that was not there and therefore they would get more than the update.

The way I understood your comments earlier, that rather than overall updates you would at least like to have questions of adequacy subdivided into areas where they need to be fixed, whether it's rurals or critical access or whatever. But if we're going to maintain the adequacy argument and especially not do updates on the ones that are plus 15, then I think we also, when we're below some threshold of adequacy -- and I'm not sure we as a commission have decided what that is, but 1.8 I could argue pretty clearly in my mind is below an adequate level. That being said, I agree with the recommendation but I think we should consider about how we maintain our consistency there.

DR. REISCHAUER: I think Alan stated it nicely. We're going to end up at the same point for all practical purposes but we should stick with the procedure and framework that we had layed out. That makes the case for how we'll deal with this issue next year a lot clearer to the world as well as justifying what we're doing this year in a more coherent way that hangs together with all of our other recommendations.

MR. HACKBARTH: It requires an explicit finding that 1.8 percent is inadequate. Is it the 1.8 that's inadequate or is it the number of losers that are inadequate? Is it how far the losers are from 1.8 that's inadequate?

DR. REISCHAUER: All of this is a judgment, and the general feeling of discomfort which leads us to believe that there should be a boost of something like 1 percent and then moving forward, market basket minus productivity plus S&TA.

MR. HACKBARTH: Other reactions to that proposal?

MR. SMITH: For reasons of consistency and clarity I think Alan's proposal makes awfully good sense. It does get us closer,

Alan. I don't know whether it's a negative implication or not. I know it's an implication we will be asked subsequently to wrestle with is, okay, you have implicitly stated that 1.8 is too low? What about 3.8 or 15.4? We are sliding -- Bob, you're right it is a judgment call and we ought to make it.

DR. REISCHAUER: It has a lot of different dimensions and we don't want to give particular weight to one or the other.

MR. SMITH: But we are. We have in this conversation and we will in the text. I think Glenn said it clearly. What has troubled us to the point of declaring inadequacy is not any capital market data, it's not any access data, it's not any patient discharge data. It's a 1.8 average margin. That is what has rung our bell, or killed our canary.

MS. RAPHAEL: I think Jack made a good point, which is we need to look at the trends here and not just one year.

MR. HACKBARTH: Julian?

MR. PETTENGILL: On the other side of that, a couple of things. One is, the recommendation is for one year only. Next year you get to revisit it again. And when you ask the question about whether current payments are adequate next year you will be in effect revisiting the question of whether you overshot or undershot this year. So that's one way in which the level of uncertainty that you should be carrying around here is perhaps smaller than the margin level would drive you to.

The second thing is, as David pointed out, the margin is only one factor here. You have the other indicators and they're not showing problems.

In addition to that, the margin distributions that you look at for Medicare are extraordinarily wide. I think we've said this to you before and we've shown you data, and we can do it again, we would probably should do it again, any group you can define, I don't care what it is, has a very wide distribution of margins.

So what exactly does that mean? When you put that together with what total margins look like we've shown you also that there's no relationship between Medicare margins and total margins.

So it hospitals' behavior is driven by what their overall financial condition is rather than by what is going on precisely with Medicare, should you react strongly to a 1.8 margin in one year? I don't know. I think there's a level of uncertainty here that you should reach to, but don't over-react.

MS. RAPHAEL: You have sectors here like nursing homes and home health that have very small total margins but high Medicare margins. Here you're saying we have the reverse, we have higher total margins and lower Medicare margins. So what does that lead you to do in terms of a consistent stance?

MR. PETTENGILL: For hospitals what you have is no relationship between Medicare margins and total margins.

MR. MULLER: Some of this goes back to the DSH discussion of prior years where one of the reasons you have this inverse relationship between Medicare and total is that hospitals that had high Medicaid had lower total margins. By having an DSH payment as a matter of policy it drives up your Medicare margin.

So in a sense, a policy judgment has been made to drive up the Medicare margin because you have a low total margin because you have Medicaid.

So I would say there's a real policy reason for that inverse relationship by and large because the reason you have low total margins is high Medicaid and high uninsured. So I don't agree with your hypothesis at all. I think there's a real policy reason for that relationship that has been well-established for however long DSH has been around.

DR. MILLER: Fundamentally I think what we're asking here is whether we're making a conclusion that it's inadequate now and applying the framework or whatever the case may be and then making a recommendation, or whether we look at this and make this judgment a year from now. Part of what we're talking about here -- the legislation passed a month ago and there's a lot of activity about to happen and starting to happen now and this is our best shot at modeling the impacts of it. But there's a lot of uncertainty that exists just in that.

MR. MULLER: But you're showing 1.7 for 2002. I think Carol and others have made the point, several people have made the point there's been a trend here that's going on for a while that has been going down, costs have gone up for the reasons well-articulated inside the chapter. So I don't think anybody is just saying there's a point estimate that has hit us today and we're saying, eureka, we never knew this. We've been watching these trends for quite a while and whether one uses Bob's metaphor of the canary in the mine, there seems to be evidence accumulating over the years that costs went up more in this field, and they may go up in other fields as well.

As I argued in response to Julian, I think there's a reason why Medicare and total margins can be, if not totally inversely related at least highly negatively correlated, and that's a policy that has brought us to that in part. So I think it's a cumulation of evidence, not a single point estimate. And I think whether it's in terms of Sheila's initial admonition to us that we should put this into context rather than just saying, there's a point estimate here that has taken us over the line. It's a cumulative discussion, cumulative evidence that has caused us to say, this one is too low, and that's what I liked Alan's formulation of it. But I think it's not just one thing.

Also if we're sitting here a year from now and the estimate for 2003 is also at the 1.7 level and so forth -- I agree with you, it's hard -- to necessary to forecast '04, '05, but '02 we're showing here is at 1.7, which is a marked decrease from the 4.1 and 5.1 that we're showing for the two prior years.

DR. ROWE: I think it's important to take both sides of each of these arguments just like I suggested if there's no margin that's too low there shouldn't be any that's too high. As Julian says, you don't have to make a change because it's only an annual adjustment and if you missed it you can make it next year. If we made it and it was more than we need to, we can compensate next year in the same way. So that doesn't persuade me in one direction or the other.

I think I'm concerned about what Bob said about the latency

here, that by the time you see effects in some of these dependent variables that we pointed out we haven't seen, it may be too late. Things crash and then it takes a while to come out.

I remember discussions with the administration after the so-called Balanced Budget Act of '97, two years into the academic medical centers were screaming and the administration was saying, we don't really see evidence that you've having -- this isn't changed, that hasn't changed. Why don't we wait? It's a little hasty to put money back in. We think it's going to be okay. Then by the time things got around to getting corrected a little bit there were a number of institutions that were very severely affected.

So I think our goal is to have as smooth a curve as possible. We don't want crashes and then peaks of big margins and then crashes and peaks. That's the problem with federal policy in these area. Don't we want as smooth a curve as possible? Isn't it likely that by throwing a little more on the table here we're more likely to have a smoother curve than a spiked curve? That's my sense of what I'm hearing and what I'm seeing in the numbers.

MR. HACKBARTH: But what I hear is a consensus about the dollar amount, and the only issue is whether we characterize it as a step one adjustment, the payment adequacy adjustment, or whether we do it in step two and change the proposed increase for the following year. I think the conversation has well-captured the logic and benefits of the two approaches.

It is a change though and I'm the sort who gets nervous about making changes like this without thinking them through. What I'd like to do is just think through this some more tonight and what the potential implications of the two approaches are before we go one way or the other.

MS. BURKE: Glenn, I unfortunately can't be here tomorrow so let me just leave one further though as you think about this for tomorrow. As you look at what the possible implications would be I would give careful consideration as to whether it will have any impact on the spending implications against budget. If there's any structure that will change that I would have great concern because I think it will meet opposition if it's outside of what is anticipated, would be my guess. I don't know that it would, but depending on how you construct it and how it's characterized as either market basket or some variation that is above that, I would just worry if all of a sudden we have a budget hit that we have to explain.

DR. ROWE: We voted on a couple things earlier today that had budget reductions.

MS. BURKE: I understand that. In each of these I'm cautious about -- I mean, we will be where we are but I want to go in knowing what that is because there will be some impact.

MS. RAPHAEL: That just raises the issue of that 0.4 reduction if you don't produce the quality report, which is in current law. Nick raised the issue of if we want to say anything on that, given that we are trying to move ahead on the quality front in every sector here.

DR. WOLTER: I was just going to comment on that again,

Glenn. If we end up with whatever the approach is at a certain number and don't comment at all on the quality tie, could that be interpreted by some as we're recommending that that be moved away from? We just might want to think about whether or not we should comment.

DR. NEWHOUSE: I think we should comment. I think that's a good point. And I also think that we ought to say that in our judgment about the update factors we will ignore the effects on margins caused by non-compliance with that provision. I think in practice that's going to be, again, a judgment call, but I think the general principle is that we want the hospitals to comply with this and we're not going to, in effect, float everybody up if people don't -- to the degree people don't comply.

MR. HACKBARTH: My personal feeling is that I wouldn't want a failure to address it to be interpreted as a lack of support for the principle that the data ought to be provided and we think that's the direction to move. I do have reservations about the approach of paying differential for the provision of the data.

My own view of this is the data are important and they ought to be provided as a condition of participation in the program and we ought not have differential updates based on whether people provide data. I'm worried about the precedent that that establishes. We have a whole lot of other people with data issues and concern about the cost, but I absolutely agree, Nick, that we should not allow silence to be construed as a lack of support for getting these data. I think they're critically important.

DR. REISCHAUER: We don't think you should be able to buy your way out of providing information that's critical to maintaining and improving quality.

MR. HACKBARTH: Right. Let's turn to the outpatient piece. Chantal.

* DR. WORZALA: Good afternoon. We'll be making an update recommendation for calendar year 2005, and under current law the update should be market basket. The outpatient PPS update itself was not affected by DIMA. However, there are provisions in that law addressing payment for drugs under the outpatient PPS and also extending the hold harmless policy for certain policies. Both of those are expected to lead to higher payments than previous law.

To put your decision in context, the Office of the Actuary estimates spending under the outpatient PPS to be $21.6 billion in 2003 and about 38 percent of the payments coming from beneficiaries. As you know, we do conduct our assessment of payment adequacy for the hospital was a whole and have been talking about that up to now. Just as a point of information I'll provide you with the outpatient margins before moving on to the update.

The top line of this chart shows the overall Medicare margin, again, our principal measure of hospital financial performance because it addresses all of the service lines that hospitals provide and obviates some of the cost allocation problems. As Julian discussed we also consider a host of market factors. As Jack pointed out, the 2004 estimated overall

Medicare margin is 1.8. That does include the outpatient PPS provisions in DIMA that I had mentioned previously.

You can see the trend in the outpatient margins here and you may recall that we had slightly different numbers presented at the December meeting. As Jack alluded to, we did identify a data error in the cost reports and it turned out there was a subset of hospitals that did not have full outpatient charges reflected in their cost reports. We understand from CMS that this was an error stemming from difficulties some FIs experienced in processing claims and generating the PS&R reports. The PS&R report is the source of charges for the cost reports. Due to the omission of these charges we did overestimate the outpatient margins for 2002 in December. The final estimates presented here use imputed values for the hospitals identified as most likely to have had missing charges on their cost reports in either 2001 or 2002.

So what are the numbers? There was substantial improvement in the outpatient margins from 2000 to 2001 in the aggregate moving from negative 12.2 to negative 6, and this does coincide with implementation of the outpatient PPS. The kinds of factors that would lead to the improvements in the margins are the transitional corridor payments which were designed to temporarily add money to the system. We did have pass-through payments that were exceeding their budgeted cap in 2001. We also see from our own analysis that outlier payments exceeded their cap in 2001.

In addition, hospitals may have been sensitive to controlling costs, particularly outpatient costs, in this period in response to the uncertainty of a new payment system coming online.

As you can see, the margins then declined between 2001 and 2002 moving from negative 6 overall to negative 8.2. Again several factors explain the decline, most obviously the cost growth that we've been discussing which, of course, would cut across service lines I think. We had lower transitional corridor payments in 2002 by design and the pass-through payments were subject to a pro rata reduction in 2002, and we saw outlier payments more in line with their cap in that year as well.

In thinking about how payments might changer after 2002 there were two provisions in DIMA adding new money, the change to the drug payment where we're making separate payments for more drugs with some floors on the payment rates. Then we also have the extension of the hold harmless policy. There is one possibility that would lead to a decrease in payments and that's the end of the transitional corridors for all but those hospitals held harmless.

As Julian noted we do have some uncertainty as we move into our decision-making process and we do have evidence that cost pressures are easing, but we do not know exactly how quickly. There are some issues on the payment side as well. Consequently, we propose making the same recommendation for the outpatient PPS as the inpatient, and that would be that the Congress should increase payments for the outpatient PPS by the increase in the hospital market basket for calendar year 2005. This recommendation is the same as current law and we anticipate no

implications for beneficiaries or providers.

MR. HACKBARTH: Questions, comments?

DR. NEWHOUSE: We could clearly have a reprise of the prior conversation which I don't think we want to do but I think in terms of writing -- assuming that we're going to support the recommendation, that we again come back to our judgment about the overall pot of money since most hospitals have an outpatient department and we think it's money going to the total hospital then that's rather -- I think rather than -- we're not proposing to arbitrarily divide it up in some way between more in the inpatient and less in the outpatient or vice versa. That doesn't get to Nick's concern but I'll have a side conversation with him about how we update.

The other thing I just wanted as a small point, I assume our projected or estimates consider the -- let me ask it this way. What's the impact of the extension of hold harmless and new drug provisions on this on the outpatient side?

DR. WORZALA: Let me just get to that page again. I do have the numbers. This is from our estimates and the drug and the hold harmless provisions result in a margin that's 2/10 of a percentage point greater than the decrease from the transitional corridors. So the net of losing the transitional corridors and having these new BIPA provisions is a positive 0.2 percent on payments.

MR. HACKBARTH: Joe, on your first comment I'm not sure what you were saying. Were you saying that --

DR. NEWHOUSE: We should reiterate that we're holding with our framework that productivity -- but actually here not S&TA -- S&TA applies but that we're still uncomfortable with the overall pot of money at the hospital as an entity, and our judgment is that the hospitals need more money and we're giving them more money in part through the inpatient and in part through the outpatient update.

MR. HACKBARTH: So if we were to adopt Alan's proposal for a step one adjustment would we characterize both as a step one?

DR. NEWHOUSE: I actually didn't frame it for myself the way you framed it, was it step one or step two. It could in principle be either. I was going to go home and thing about. But so in response to you is, whatever the answer to that question is I would make it for inpatient and outpatient.

DR. ROWE: I think to whatever extent we're better off with overall Medicare margin as a better reflection, for the reasons we talked about earlier about the shift from one site to another site of health care and the changes in technology and your ability to move patients around and reallocate costs and all that we don't want to -- if any adjustment is made, make it just in one of these two pieces. That would be a mistake. That would provide incentives for what we're trying to get away from. So to whatever adjustment gets made I would then parse it across to two areas in such a way as it's neutral and it's not going to result in behaviors which we're trying to get away from.

DR. NEWHOUSE: The real implication of that, assuming we are adhering to our framework, is the difference with the S&TA and whether that does create a small difference in how we treat

these. But maybe we can take that up tomorrow.

MR. SMITH: I think the elegance of Alan's argument about consistency does argue for doing this as a step one adjustment and holding on to the productivity modification of the market basket update. We could do it in a single step. We could say we believe that because of the low overall margins this is a year in which we ought to forego the productivity target, but I think it's probably better to do it in two steps, although at 0.9 and 0.9, Alan, not one and 0.9, so we don't inadvertently step on the problem Sheila raised.

MR. HACKBARTH: Any other comments about outpatient?

Okay, as I said we'll take this up and do our votes tomorrow morning on both the inpatient and outpatient. So I think we're done for now and we'll have a brief public comment period.