MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, January 15, 2004
9:15 a.m.

COMMISSIONERS PRESENT:

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

AGENDA ITEM:

Outpatient PPS outlier policy -- Chantal Worzala

DR. WORZALA: Good morning. I'm here to talk about the outlier policy for the outpatient PPS. Of course, we've discussed this policy in the last couple of meetings, so I don't want to cover any of the background of a conceptual basis or how it actually works. I'll just focus on the policy question at hand, which is does the outpatient PPS need an outlier policy?

As we've discussed, there are several conceptual reasons you might want an outlier policy in the outpatient PPS. First, there has been a shift toward more sophisticated and more costly services moving to the outpatient setting, although it is still predominately a low pay, low cost set of services.

Second, the outpatient PPS is a fairly new payment system and it's been difficult for CMS to set payment rates, given the data available to the Agency. And in that context, the outlier could provide a cushion for rates that are too low. The best strategy would, of course, be to fix the payment rates. But in the interim, we could use the outlier to make up for inaccurate rates.

Third, the distribution of cases may not be random across hospitals. So if some hospitals routinely provide services to more costly patients, the outlier would help to compensate them for that risk. Again, it would be better to have a payment system that adequately addressed that in the first place.

The evidence, however, suggests that the arguments against having an outline are stronger. We've discussed them in the past. Here I've grouped them into conceptual arguments, findings from my data analysis, and policy considerations.

First, many outpatient services have a narrow product definition and includes many ancillary services and inputs, such as a drug, that are paid separately. This would suggest that the variability in costs across individual cases will not be great.

Second, the APCs generally have low payment rates. This means that the size of the potential loss to hospitals from having a relatively costly case is generally small.

When we look at the data, we find that most of the outlier payments have been made for services with

low payment rates, suggesting that as its operating currently the outlier policy is not covering large financial risks to hospitals. We also find that the payments are not evenly distributed across hospitals and this becomes an equity issue, given that outlier payments are funded through a decrease in the conversion factor.

Then from a policy perspective there are additional arguments. First, there is a potential for outlier payments to be made in response to increases in charges and not necessarily increases in costs. And this is due to the way the outliers are calculated, as we've discussed. Relies on outdated cost to charge ratios and we have seen that there's been a decline in the ratio of cost to charges, suggesting that charges are rising faster than costs.

Second, administering the outlier and protecting against gaming are administratively costly and must compete against other priorities for both staff and monetary resources on the part of the Agency and fiscal intermediaries.

Finally, the outpatient PPS is the only ambulatory setting with an outlier policy. However, many of the services provided can also be provided in physicians' offices or ASCs, and so having an outlier policy in one setting and not the other creates one more difference in how the services are paid across settings.

Last month I presented you with the distribution of outlier payments by service in 2001. Now I bring you more recent data. All of my 2002 results come from an analysis of a claims file that spans the period April through December of 2002 and includes 100 percent of the outpatient claims.

In 2002, as in 2001, a relatively small number of APCs, 21, accounted for 50 percent of the outlier payments. These same services accounted for only 36 percent of the APC payments. Among those 21 services, only one, a cataract surgery, had a payment rate over $400.

This slide shows some of the specific services that accounted for a large share of the outlier payments in 2002. The order of services did change between 2001 and 2002 but very similar services appeared in both years. For example, x-rays ranked third in 2001 but are first in 2002. Electrocardiograms ranked fifth in both years. These eight services accounted for 29 percent of the outlier payments but only 17 percent of the APC

payments. Again, payment rates are low.

This table groups the services by their payment rate and shows what share of outlier and APC payments went to the services in each payment band. You can see that services with payment rates of less than $50 accounted for 24 percent of the outlier payments but only 11 percent of the base APC payments. Altogether 75 percent of outlier payments went for services costing $300 or cost and these services accounted for about 54 percent of the base APC payments.

For the most expensive services, those with payment rates above $1000, the share of outlier payments is only 7.6 percent, even though these services accounted for 26 percent of the base APC payments. Thus, the higher paid and presumably more complex services are not accounting for even a proportionate share of the outlier payments.

In the last presentation, and in your briefing papers, we looked at the distribution of outlier payments by hospital group and noted that hospitals in large urban areas, teaching hospitals, and for-profit hospitals got larger shares of the outlier payments than they did of base APC payments. These hospital groups also received a greater share of their total payments through the outlier mechanism. Those patterns held in both 2001 and 2002.

This table looks at distribution across individual hospitals and tries to speak to the equity issue. The bottom line message is that most hospitals receive very few outlier payments while a few hospitals received a large share. Recall that the base payments for all hospitals are reduced to finance the outliers.

We have segmented the hospitals according to the share of all payments coming through the outlier policy so you can see that at the bottom of the distribution 10 percent of the hospitals receive less than 1/10th of 1 percent of their total payments in the form of outliers. These hospitals hardly received any of the outlier polices as a group, 1/10th of 1 percent. In contrast, at the top of the distribution, 10 percent of the hospitals received 4.8 percent or more of their payments through the outlier mechanism. As a group -- yes.

MR. DeBUSK: Let me ask you something. You're looking at the percentages of hospitals. What about the number of beds?

DR. WORZALA: Well, this is an outpatient.

MR. DeBUSK: It could still be capacity.

DR. WORZALA: Right. I don't have that information. I could try and get it for you.

MR. DeBUSK: So the number of hospitals may be insignificant on that basis.

DR. ROWE: [off microphone.] These are the larger outpatient facilities seeing give times as many, 10 times as many patients.

MR. DeBUSK: Right, that's the point.

DR. WORZALA: That's true, this isn't weighted by revenue, for example.

DR. ROWE: [off microphone.] Outliers as a percent of patients or as a percent of plans.

DR. WORZALA: It's outliers as a percent of payment. I'm not looking at the straight outlier -- it's not the 1 percent of hospitals that got the most outlier payments. It's looking at outliers as a share of their total payments.

DR. WOLTER: One other question I had on this was would it be a fair inference that say in that top 10 percent that are getting 35 percent of the outlier payments, that the majority of those payments are in the lower-priced procedures?

DR. WORZALA: Yes.

DR. WOLTER: That would be a fair inference, just based on the other?

DR. WORZALA: I think that's a fair inference.

So you have 10 percent getting 1/10 of 1 percent of the outliers and top 10 percent getting 35 percent of the outliers.

I should note that moving forward after 2003, when CMS started to use more current but still at least one year lagged cost reports to calculate the CCRs, you may see that top band sort of moving back because there will be less opportunity for gaming. But still it will still exist.

So we saw from our hospital group analysis that teaching hospitals have a greater reliance on the outlier payments than other groups. The major teaching hospitals in 2002 received 2.4 percent of their payments as outliers compared to 1.7 percent for all. And I should note 1.6 percent for other teaching hospitals.

Since teaching hospitals do have a mission that includes treating sicker patients and promoting innovative products we might want to look more closely at their outlier payments.

So what we did was to repeat the previous

analyses for the sub-group of teaching hospitals and we did find that they had a similar distribution of outlier payments by service as all hospitals did. X-rays accounted for the greatest share of outlier payments to teaching hospitals, about 4 percent. Similarly, services with low payment rates, $50 or less, accounted for 24 percent of the outlier payments. The services with the highest payment rates, those over $1000, did not account for a large share of the outlier payments received by teaching hospitals, 8 percent.

We also looked at the distribution of outlier payments among teaching hospitals and found a similar level of variation as we did for all hospitals. The bottom half of teaching hospitals received 16 percent of the outlier payments while the top 10 percent received 42 percent.

After considering the data and arguments presented above we propose the following draft recommendation. The Congress should eliminate the outlier provision of the outpatient prospective payment system. This has no spending implications because the outlier policy is budget neutral and the funds would simply be returned to the conversion factor.

The policy should have no material impact on beneficiaries; access to care, given that the policy doesn't seem to be covering large financial risk. Hospitals that had been receiving large shares of the outlier payments may have lower revenues. Other hospitals will receive greater base payments when the outlier funds are returned to the conversion factor.

DR. REISCHAUER: Just in how we characterize the budgetary impact on this, ideally it should have no budget impact but historically it would have because while it's supposed to be budget neutral, it never has been.

DR. WORZALA: Could we score that as a savings or something we put in the text?

DR. REISCHAUER: You know, taking off my CBO hat, no, but I think we should mention it. As implemented, this policy has cost money and is likely to in the future.

MR. FEEZOR: Chantal, it's a thorough analysis and I compliment you on that.

I got the feeling as I started reading it that somehow differently from other chapters that we've done where we've made major recommendations, we sort of started with our mind made up. And I don't know that

the analysis and the process that we got there, but it just sort of the way it was worded or my conclusions.

So I think we do a thorough analysis of sort of the financial redistributional and the hedging impact of the outlier policy, in this case. But if you look back at sort of the public policy objectives, one was sort of the hedging or the financial aspect. The other was the access issue.

I don't think we do as good a job and I think we need to spend a little bit more time of either assuring policymakers, including ourselves, that yes, that will or will not in fact impact access for the fragile or the complex on the outpatient basis.

Your last slide, when you talked about sort of the correlation, one would assume between university or teaching hospitals and their patient mix, maybe you can make some deductions. But I think we need to make a much stronger case, that we start out in the first part of our chapter here, saying the other reason is to make sure that there would not be a disincentive for hospitals to, in fact, treat the complex and high risk case.

I just don't think we've made as strong a case here as we need to, whether it's anecdotally, whether there are some studies or a little further correlation between where those patients go in the patient mix would be helpful.

DR. ROWE: Can I ask Bob a question about the budget observation? If the implementation of the outlier policy resulted in increase in expenses, let's say from X to X plus Y, if we get rid of the outlier policy does that mean that the total amount of money that's going to be distributed across hospitals is X plus Y? Or do you think it would go back to X? In which case it would actually be a savings by getting rid of the so-called budget neutral outlier policy?

DR. REISCHAUER: It would go back to X, because what happens now is the Secretary says I expect outlier payments to be 2 percent of the total, sets the parameters so as to meet that total. It turns out to be 3 and the trust fund or the S&I trust fund eats 1 percent and we never go back.

DR. ROWE: Thank you, because I was thinking that an alternative that somebody might say is okay, you want it to be budget neutral. We'll take the amount that was spent last year and we'll distribute it across the hospitals, which was therefore budget neutral. But

that has already embedded in it the Y component, which was the increase associated with the implementation of the outlier policy.

DR. REISCHAUER: The question on scoring is whether CBO, when projecting forward Medicare spending, assumes that the Secretary is going to be wrong in the future, a bias in there. It probably does.

I want to just build on the last comment, and that is I think you're right, that we have to explain very carefully the other side of this argument. But I'm not at all convinced -- you know, we do our breaks all the time, teaching, urban, rural, whatever, big, small. And it's not clear to me that necessarily there's sort of a behavioral element to his that these might be categorizations that are highly correlated with something else.

If the outliers were predominantly for complex, expensive kinds of things, I'd have a little more sympathy for this. But when we're talking about an x-ray, there's something else going on here. And I'd want to see a multivariate analysis, one variable of which was change in your cost-to-charge ratios.

It could be that teaching hospitals are cruising down this curve at a faster rate that the average, as are for-profit hospitals and things like that. And then, when you threw in a teaching/non-teaching variable it would be insignificant. But we could go through this and think exactly what it is that we think produces this kind of behavior. And in the best of all possible worlds, it would be teaching because the teaching would have more complex cases and more variability in those cases and all of that. But when we look at this aggregate data, it doesn't look like that's the case.

Or we could look at the amount that the teaching hospitals get and find that that's where all the complex, the outliers for complex procedures are and in the other hospitals it's all for x-rays.

DR. ROWE: But there is a difference in the teaching hospitals between the major teaching and the other teaching. There's a big difference. So while Chantal said in her slide shows that the distribution of outlier payments seems to be same in teaching hospitals as in the non-teaching, in the major teaching there's this huge difference between major and other teaching. That might be consistent with the argument you're saying about those because those are the kinds of procedures

are concentrated --

DR. REISCHAUER: About those or about variability of cost-to-charge ratios within subgroups of categories of services is greater in those hospitals. Who knows?

DR. ROWE: When you back to not having an outlier policy and there's this budget neutral effect, are the funds distributed within categories of hospitals? That is, the funds that went to teaching hospitals go to teaching hospitals? Or is across all hospitals?

MS. DePARLE: It's back into the regular APCs. So whatever is spent, that's what's spent. But I would assume that the actuaries at least, in projecting the amount for the next year, would start from a base that included however much the payments were in the outpatient prospective payment system the previous year, which would include in new technology add-ons and the outliers and everything. What you think, Mark?

DR. MILLER: Chantal, we've talked about this. I'm hoping Chantal answers the question, which is why I didn't turn the microphone on.

I thought when we talked about this, if I recall the conversation, you were saying that the piece above the outlier amount was taken out of the base payment for the purposes of determining budget neutrality.

DR. WORZALA: That depends on which process you're about. That refers to recalibrating the relative weights. So any sort of spillover payments that happen are not counted for the purpose of recalibrating the relative weights. But when anybody accounts for the spending, all payments are included.

DR. MILLER: So when you publish in the regulation the next year the base payment amount, which is a product of whatever the previous was plus the market basket, the additional outlier payments are still in there and inflated forward?

MR. WINTER: When OAC or CBO has their series of what spending has been, obviously all of these payments are included. But when you set the conversion factor, you are not including payments that went above and beyond what you had planned.

DR. MILLER: So in 10 seconds or less, for purposes of the baseline, it sounds like it's in there. But for the purposes of setting the payment rate, it's backed out before it's inflated forward?

DR. WORZALA: That's correct.

DR. MILLER: Nancy Ann, does that get to your question?

MS. DePARLE: Yes.

DR. WORZALA: Can I just make one comment on the access issue? Conceptually, for their to be an impact on beneficiary access to care, hospitals have to feel that this individual patient about to come through my door will cost me a whole lot of extra money, enough so that I'm going to find a way not to treat this person.

And if they're going to cost you a little bit more on an x-ray, would a hospital do that? I mean, I'm sure there's what it can be done. And that's very crude, that's very conceptual and cold and calculating, but that's sort of what you're saying in order for there to be an impact on access I think.

DR. REISCHAUER: And a lot of these things are a component of a larger service bundle, so you might, in your formulation, lose on the x-ray but pickup on the implanting the defibrillator.

DR. ROWE: I don't think that's how the hospitals think. Or some of them.

DR. WORZALA: I don't think so. That's just what would have to happen in order for the access problem to be there.

DR. ROWE: I'll tell you what I do think may happen and that is that services that were available in some hospitals on an outpatient basis will no longer be available on an outpatient basis and will only be available on an inpatient basis.

MS. DePARLE: That's what people said when we did the outpatient PPS.

DR. ROWE: Yes. And if you look at the major teaching, which get a disproportionate piece of this, they may decide that they want to no longer offer this in an outpatient, just do it inpatient. Which is fine. I don't think that's an access problem for a Medicare beneficiary. But I think that might on the margin, particularly if there's a whole set of these kinds of services offered that require certain infrastructure.

DR. WORZALA: But that would be a systematic payment issue not a random costly individual case kind of argument.

MR. DeBUSK: Chantal, Glen, is this system working now the way it is? Is it broke?

MR. HACKBARTH: The outlier piece, yes, that's

the gist of the recommendation, that it is broke.

MR. DeBUSK: I look back at this outlier piece and it's activity based. And allocating of overhead, as we talked about yesterday in the hospital setting, that's not working. I'm a little reluctant to tear something down here or make this recommendation or vote on it if we're going away from an activity-based system where under that system the cost is allocated where it needs to be.

It looks to me like we're word going in the opposite direction. We're doing more bundling. Maybe we should in this particular instance but theoretically it doesn't look to me like we're moving in the right direction.

MR. HACKBARTH: I'm not sure, Pete, that I'm following. The gist of what we're recommending is that this is broken because it's putting a lot of outlier additional payments focused on services with very small bundles and low unit prices and that's not consistent with the basic concept of an outlier system. It's not getting the money to the right place. We'd be better off putting the money in the base rate as opposed to having this distribution that this system is producing.

MR. DeBUSK: Maybe so.

DR. NELSON: Help me understand how the charges are established. The charge-to-cost ratio adjustment, I understand that. But if an institution decides to charge $90 for an x-ray, do they charge $90 for just some x-rays or do they charge $90 for all of their x-rays? And if so, how do they determine which ones to charge $90 for and which ones to charge only a normal fee, usual fee?

DR. WORZALA: As I understand it, the law prohibits a hospital that sees Medicare patients from charting Medicare patients a different amount than other patients, so the charges would be equal across all patients.

DR. NELSON: So if I can pursue it, so the outlier charges are established by the facility because that's what they charge all of their patients?

DR. REISCHAUER: But nobody pays charges. A few Saudi Arabians fly in and pay charges but CareFirst and Aetna and those people aren't paying charges.

DR. NELSON: I guess I don't understand the rationale for this being utilized for relatively low-cost services as duh. I guess what I'm saying is why doesn't the whole world do that if it is, as it appears,

a potential license to steal? What is the restriction? Why is it only such a low percentage? Help me understand.

DR. WORZALA: I believe, and please help me those of you who run private insurance companies, I don't know that any other purchaser would have any kind of outlier or -- I'm not getting the word in my head -- but any kind of additional payment for low-cost services. They will have a stop-loss provision but it's $100,000 or something like that. So none of this kind of outlier additional payment would accrue to any outpatient service that I'm aware of.

DR. ROWE: Depending on the way the contracts are written, you can be subject to autonomous increases in charges on the part of the hospitals, just to rev up their chargemaster payments and stop-loss provisions are generally being removed from hospital contracts. Or many private insurers sell stop-loss insurance as well was regular insurance so it gets very complex. I think that the private insureds are less vulnerable than the Medicare system in general and becoming increasingly less vulnerable all the time because of changes in the way the contracts are written.

DR. MILLER: I guess this is a question. If you're a hospital and you raise your charges, that's a negotiating position for private payers, the private payers will come in and say I want a discount off charges. So to the extent that you've raised your charges, you're positioning yourself for that. And to the extent you're doing that and the cost-to-charge ratios lag a couple of years, that just drives more money into the outlier payments on the Medicare side. Is that right, Chantal?

DR. WORZALA: Yes, that's certainly fair.

DR. ROWE: What is clear is the system is broken. The point that Glen made about this being a distribution of -- did you see these services, EKG. I mean, these are very low-cost services that somehow should be getting paid for in the base rate.

MR. HACKBARTH: I think we need to move ahead, Chantal. So let's turn to the recommendation.

All opposed to the draft recommendation? All in favor? Abstentions?

Okay, thank you.