MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

**Friday, October 10, 2003**
**9:02 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
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:**

**Assessing the outlier policy under the outpatient PPS**
**-- Chantal Worzala**

DR. WORZALA: Good morning.

We're back in the details of the outpatient PPS. Hope I don't -- never mind.

My presentation will have three parts this morning. First, a conceptual discussion of the rationale for outlier payments cutting sort of across systems. Second, a presentation of the outpatient PPS outlier policy as it was implemented this year, 2003. And finally, a discussion of some policy questions that the Commission may want to consider for the March report.

Outlier payments provide additional funds to providers when the services they furnish are exceptionally costly compared to Medicare's payment rates. Conceptually, the outlier payments serve as a kind of insurance protecting hospitals against unexpected large losses. By providing these additional payments, the program takes away some of the incentive to avoid costly patients and thereby helps to promote beneficiary access to care.

If we look at outliers as a form of insurance, that suggest two situations where you might want an outlier policy. First would be when there's considerable variation in the cost of providing the services included in the product that Medicare is paying for, such as the inpatient case or the outpatient APC. This is because Medicare sets payments based on average cost. Thus, if a payment group has great variability around that average, the provider is more likely to treat a beneficiary with extraordinarily high costs. This variability in costs is likely to be linked to the product definition. Is the product defined broadly or is it defined narrowly?

A little bit of contrast to get that concept across, the inpatient, of course, is a very broadly defined product covering the entire stay. If you look at the outpatient PPS, it's a much more mixed product definition. There are some broad APC groups such as pacemaker implantation and others are very narrow, an x-ray, an electrocardiogram, a drug.

The other situation where you might want an outlier payment is when the potential losses are great. In that situation providers would be at increased financial risk so you would want to diminish that risk through an outlier policy, both to help the provider and to protect beneficiary access to care.

Of course, when these two things coincide and there is a lot of variation in the costs and the potential losses are great the need for an outlier policy is magnified.

I would note one additional situation where you might want an outlier policy and that's when the risky cases or the expensive cases are not randomly distributed across providers. If one set of providers is more likely to treat the costly beneficiaries then the outlier policy would shield them from financial losses.

This chart shows what the outpatient payment system looks like when it comes to the size of the potential loss. What we've got are the APC groups and their payment rates. We see that most of APC groups have low payment rates per unit. So two-thirds have a payment rate of less than $500 and 75 percent of the APCs have a payment rate of less than $1000.

There are, however, some highly paid services. For example, insertion of a cardioverter defibrillator as a payment rate of $17,000. What this chart shows is just the distribution of the APC groups. It doesn't have the volume in there, but much of the volume is in the lower paid APC groups.

MR. DeBUSK: [Off microphone.] Does this have the C-code information in it?

DR. WORZALA: Yes, it does. This is 2003, so most of the devices are packaged.

MR. DeBUSK: [Off microphone.] Packaged? Okay.

DR. ROWE: The $17,000 includes the device?--

DR. WORZALA: In the case of the cardioverter defibrillator, I would have to go back and double-check whether that's still a pass-through in 2003 or not. I apologize, I don't know that detail.

DR. ROWE: That would be a very high rate just to insert it.

DR. WORZALA: It probably does but I would have to go back and double-check.

A number of payment system have an outlier policy and they do have certain elements in common. The first is eligibility, which services can qualify for an outlier payment. The second is the cost threshold, how high must a providers costs be to qualify for an outlier? Third, the marginal payment factor. If you're eligible for an outlier payment, how much additional payment will you receive? What share of the costs above the threshold will be covered by Medicare? Finally, the target amount. What percentage of total payments will be set aside to fund the outliers?

The outlier policy for the outpatient PPS is required by statute. Like the outlier policy in other settings, it is budget neutral so CMS reduces the payments for all APCs to fund the outlier payments. Congress set an upper bound on the outlier payments of 3 percent. CMS has so far targeted outlier payments below that limit. In 2003 the set aside was 2 percent. If actual payments exceed or fall below that target of 2 percent, no effort is made to modify the conversion factor to try and recoup or return those funds in later years.

In 2003, the outpatient PPS provided outlier payments to all APCs except for pass-through drugs and devices. This includes both the broadly defined APCs ---

MS. BURKE: I'm sorry, can I just ask a question? If you could go back to the prior, just remind me. If, in fact, the adjustment is made, is it made prospectively?

DR. WORZALA: Yes.

MS. BURKE: Essentially if there's an overpayment in the following year, they essentially adjust downward?

DR. WORZALA: No, they never try to adjust. They set the

target, they reduce the conversion factor, but there's no look-back. There's no look-back to say I paid too much last year, therefore I'll reduce the conversion factor more.

So in 2003 we had outliers for everything except pass-through drugs and devices. This includes both the broader bundle such as the surgeries and very narrowly defined groups such as a x-ray or an electrocardiogram. And CMS estimated that a cost threshold of three-and-a-half times the payment rate for the APC and a marginal payment factor of 45 percent above the costs of the threshold would meet their 2 percent target. So to qualify for an outlier payment, the cost must be three-and-a-half times the payment rate. Any costs above that threshold are reimbursed at 45 percent.

You do have a detailed example in your briefing papers of how the outlier was calculated. Here I'm just going to review the process that's followed. Outlier payments are, of course, based on the estimated costs and the FIs estimate costs by taking the current charges submitted on the claim and multiplying them by a cost-to-charge ratio that comes from the most recent tentatively settled or settled cost report.

But even using the most current tentative settled cost report generally results in a time lag of one to two years between the date of the cost-to-charge ratio and the submitted charges. So you come up against the situation where charges have increased at a faster rate than costs in the intervening period. The CCR will result in an estimate of costs that are higher than the actual costs.

And we have seen some evidence in recent years that charges have been increasing faster than costs on average, and for some hospitals at a much faster pace.

There are, of course, may reasons to increase your charges faster than your costs. But no matter what your motivation, the pattern will result in unwarranted outlier payments and those payments will be paid for by other hospitals. So since the outliers are budget neutral that can, of course, have a distribution affect which we'll look at in this slide.

This shows the distribution of outlier payments among hospitals across three different groupings, location, teaching status, and ownership type.

DR. ROWE: This is just the outpatient?

DR. WORZALA: This is just the outpatient outlier payments. I didn't put that in the title, I apologize.

The percentages in each cell should cum to 100. They don't exactly due to rounding and also an inability to classify hospitals.

So you can see from the table that in each group one type of hospital received a disproportionate share of the outlier payments. It doesn't however tell us why. This could be explained by differences in either costs or charges.

So if you look at it by location, hospitals in large urban areas received a greater share of the outlier payments, 57 percent, than they did of the APC payments, 46 percent. If the outliers were completely randomly distributed, or the cases really and the outliers, we would expect those two numbers to be

the same, 46 percent of APC payments and 46 percent of outliers. But you see a disproportionate share of the outlier payments going to hospitals in large urban areas. Of course, for hospitals in other urban and rural areas, the share of outlier payments was lower than the share of APC payments.

If you look at it by teaching status, the major teaching hospitals received a greater share of outlier payments than APC payments. And looking at it by ownership, the for-profit or proprietary hospitals received a disproportionate share of the outlier payments, as well.

MS. DePARLE: Chantal, how did you define other teaching?

DR. WORZALA: It is defined by the resident-to-bed ratio. And so it's the exact same definition as we would use in our inpatient hospital analysis.

MS. BURKE: Chantal, I was just interested in your comment that the disproportionately is in fact driven by the issues around costs and charges. Is there any impact of the acuity of the particular patient? The distribution of APCs may be what they are, but is there not an impact among APCs and their allocation based on the acuity of the patient that may drive the charge?

DR. WORZALA: Yes, I think that would be where you really are seeing this driven by differences in cost structure and the cost could be a function of the patients that you see. It could very well be that the risky patients, the more expensive patients, are not randomly distributed across hospitals and certain hospitals may, in fact, see more costly patients.

MR. MULLER: [Off microphone.] We know that.

DR. WORZALA: Exactly.

MS. BURKE: So I would only caution you about the use of the term disproportionate because in fact, it may be appropriate. That's my only concern, is that the resulting allocation, the share of the outliers, may in fact track the acuity of the patient and not simply a function of some people are bigger piggies than others.

DR. WORZALA: I didn't mean for disproportionate to be used that way. It was just a different in proportion of the APC payments versus the outlier payment. I tried to predicate all this with the explanation it could be charges, it could be costs, and we can't disentangled that from what's in front of us. And hopefully additional analyses that we do over the next few months will help us disentangle some of that.

Here are some policy questions that we might want to ask. The first would be does the outpatient PPS need an outlier payment? I think there are a number of arguments supporting a no response to that question. First, many outpatient services have a narrow product definition, and this includes a lot of ancillary services and inputs that are paid separately which would suggest that the variability in costs will not be great.

I haven't shown you any analyses by service type because I want to make sure everything is right before I present it, but our initial results are suggesting that some of these sort of fairly simple ancillary services are receiving a fairly high share of outlier payments, which I think poses some questions.

Secondly, as we saw earlier, the APCs generally have low payment rates so the size of the potential loss is not that great. Third, I think there are some equity issues here. This is a budget neutral system, so the base payments are lowered to find the outliers, but we know that the outlier payments themselves are not evenly distributed.

In addition, there is the potential for outlier payments to be made in responses to increases in charges not necessarily increases in costs. Again, I think that's an equity issue.

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. So when you have an outlier policy in one setting and not the others, you have just one more difference in how the services are paid for across settings.

I do believe that Ariel has heard from some ASCs who would like an outlier payment.

However, there are also arguments supporting a yes answer to the question of does the outpatient PPS need an outlier policy. There has been a shift toward more sophisticated and more costly services being performed in the outpatient setting. That's a pattern that's likely to continue in the future.

Second. this is a pretty new payment system and we know that CMS has had some difficulty setting the payment rates given the data they have available. So some would argue that the outlier system provides a cushion in the event that rates really are just too low.

Of course, it would be best to fix the payment rates but in the interim maybe there is a role for the outlier.

And third, as we've been discussing, I think the distribution of cases across hospitals may not be random. And so if you're routinely seeing more expensive cases, the outlier helps to compensate you for those additional costs.

Finally, if we decide that the outlier is appropriate for the outpatient PPS, are there any changes to the design that are warranted? Currently most services are eligible for outlier payments, including electrocardiograms, x-rays, setting a cast. These all can be given an outlier payment.

Does that makes sense or should we limit the eligibility to certain types of APCs such as surgeries or more broadly defined products?

Second, currently the threshold is set as a multiple of the payment rate regardless of the actual dollar amount. So if we go back to the example of electrocardiograms, they have a payment rate of $19. Does a low-cost service like that provide a sufficient financial risk to warrant an outlier payment?

Other outlier polices do have an absolute dollar threshold that must be met before an outlier payment is received. Is that something that might make sense in the outpatient setting as well?

And of course, changes along these lines may have implications for the target amount as well. If fewer services are eligible for outliers, then you need less funds taken out of base payments to fund outliers.

And very quickly, over the next few months I will bring you additional data to help inform these policy questions, looking more at the distribution of outliers by hospital to look at some of the distributional issues. And then looking at outlier payments by APC to inform some of these discussions of design.

And finally, I'm planning to bring you data from 2002 although I've come up against some data issues so we'll see what happens there.

DR. NEWHOUSE: Chantal, you could do some analysis that would help me think about this, which is for the higher paying APCs what is the coefficient of variation? That is, you pointed to a narrow bundle being a reason not to have an outlier scheme. And in the narrowest of bundles there would be one service and there would be no variation at all so he wouldn't need an outlier scheme. And we have outlier schemes when we think there is variation as in PPS, and I think also in home health.

So what is it here and how did the variability compare to these other systems?

That seems to me also would inform us in thinking about how much should be set aside for outliers because if it was say somewhere in between the one extreme of the physicians system and probably the hospital system or the home health system, we'd have a payment percentage that was in between.

And then on a separate issue, if there is an outlier scheme I think as a matter of principle we would want to fix dollar threshold as in the hospital PPS.

DR. REISCHAUER: How do you calculate the coefficient of variation?

DR. NEWHOUSE: A standard deviation over the mean.

DR. ROWE: [Off microphone.] [Inaudible.]

DR. REISCHAUER: Thank you, Professor.

DR. ROWE: Even I know that and I'm a doctor.

DR. REISCHAUER: I can get my Ph.D. taken away from me by Professor Newhouse.

What's the data that you use?

DR. NEWHOUSE: But you have the threat of taking my professorial title away.

DR. REISCHAUER: Don't you have to use the stuff that the hospitals are submitting, which maybe is biased?

DR. NEWHOUSE: Yes, that's right. What do we use in the hospital system? I'd still like to know what.

DR. MILLER: Can I ask one question on this, and I want to be clear on this which is why I'm asking. In some instances, isn't your point that it is effectively coming down to one service? But I wanted to also just make sure that that point was clear to everyone, that often it is one service that we're talking about that the calculation is being taken on.

MS. DePARLE: I'm sorry, can I just ask a contextual point? It's been a while since I looked at this and I thought it was in the paper but it isn't.

How much is Medicare spending? What's the 2002 data on outpatient spending? And what has the trend been over the last few years, I guess since '98?

DR. WORZALA: We had a really sharp increase in 2001 that

took us up to $18.6 billion under the outpatient PPS. And the projections are for continued rapid growth. There was real growth in the '80s and the early '90s and there was a little bit of a slowing down in the mid- to late-'90s with real acceleration since the implementation of the outpatient PPS.

DR. MILLER: [Off microphone.] Chantal, I thought the last COACT number was --

DR. WORZALA: That is for 2004 protected.

MR. DeBUSK: I've got two or three points here. In assessing the outlier policy under the outpatient prospective payment system I notice in the last bullet point we're looking at using data from 2002. Do we have access to any more recent data? Isn't there some claims data that CMS has access to?

MS. BURKE: We were using '96.

DR. WORZALA: I've presented data from 2001. We have up and running the 2002 CMS data but we're having a few data issues and we may have to go back and get a new dataset.

MR. DeBUSK: Yesterday I got out of the penalty box because Nick took up the issue about my normal complaint about the availability of data. I guess we're right back at the same place, the data is not current enough to even discuss the subject hardly. But anyhow, let me go to the next piece.

Eligibility, all APCs except pass-through of drugs and devices. Last year, we were talking a lot about the implantables and the costs and the overrun, the last two years. Now that we're into full-blown use of stents and what have you and drugs, do we have any idea what this looks like? Is there any data out there to tell us?

That is outside the budget neutral piece, is it not? These C-codes that still exist.

DR. WORZALA: No, the pass-throughs are also funded budget neutral.

MR. DeBUSK: The drugs?

DR. WORZALA: The reason we don't have outlier payments on pass-through items is because pass-through items are paid 100 percent of cost. And so there's not a fixed payment rate to compare the costs against.

DR. MILLER: But to Pete's point, if the pass-through payments exceed the budget neutral amount, then there's a pro rata reduction. And I think we're not a position at this point to calculate whether it's going to exceed that; is that a fair statement? Is that what you're driving at, Pete?

MR. DeBUSK: Yes, it is. Is that set at 2 or 2.5 percent?

DR. WORZALA: I'm going to be honest, I'm struggling in my mind whether it's 2 or 2.5 percent. It's 2.5 in 2003 and 2 percent in 2004 is my recollection, but I would need to double-check that.

But is your point that in 2002, for example, when there was a pro rata reduction that pass-through items should have been able to receive outlier payments?

MR. DeBUSK: I was just wondering, when I look at being neutral, we actually spent more money. Wasn't there an overrun of about $600 million in 2002; isn't that right?

DR. WORZALA: In 2001, we know that there was considerably

more spent, almost four times -- well, three times what was set aside. In 2002, I don't think we know yet. We need to look at the data to tell me.

MR. DeBUSK: There was a projection though of $1.7 billion right, initially? Isn't that right?

MS. BURKE: On pass-through.

MR. DeBUSK: On pass-throughs. But that was never actually reached. It turned to be something more like $600 million dollars.

DR. WORZALA: I honestly don't think we know yet. That number was the 2002 projection and I haven't seen any data from the 2002 claims to see how much was actually spent on the pass-throughs.

MR. DeBUSK: The biggest thing here, I guess, is we don't have any ability to look at what's happened after the program memorandum of January in regards to the statewide averaging?

DR. WORZALA: That's true. Yes, we don't have any 2003 data on the outliers although potentially we could get the first three months or something of 2003.

DR. MILLER: Or to put it differently, to the extent that that problem was still in play it would be reflected in this data. To the extent that the program memorandum -- corrected anything, we have not seen the data to see what the effect is. I think that's your point.

MR. DeBUSK: Yes, that's fair enough.

MR. FEEZOR: Thank you, Chantal, a good presentation. A couple of things.

I guess I would echo Joe's comments that if it does look like we're going to be proceeding on this, some staff work around a dollar threshold, I think would be very helpful prior to going into that.

Secondly, when you breakout more information on a hospital-specific basis, my first instinct would be I'd love to know which are the financial or billing systems the entities are using. That's probably not feasible. But perhaps hospitals that are under common ownership might be an interesting array. I won't say anything more.

And then third, follow up I guess on Mark's observation that it's largely maybe one or two procedures or issues we're talking about here. I wonder if some effort to sort of look into the future in terms -- and I mean near future, next three of five years -- of what might be evolving to the outpatient basis, so that we would have some idea whether it's going to be that limited.

And then the final thing is, I shared with one my colleagues on the Commission here that your back ground must have been with Aetna or an intermediary and the financial example that you used, you're off about $100 that you have, the example used was not calculated properly. So you probably need to correct that.

DR. ROWE: I object.

[Laughter.]

MR. FEEZOR: And as a payer, I used to appreciate those.

DR. ROWE: That was the old Aetna.

DR. WORZALA: I apologize. Feel free to pass editorial

comments on paper.

DR. ROWE: A couple of points. One is I think my answer to the question of whether there should be an outlier for this is yes. I'm concerned about the fact that we don't want to have any payment policies that influence the site of care in a way that has care take place in other than the best place for it to take place. And if we have an outlier policy in the hospital and we don't have an outlier policy out of the hospital, and if some of these hospitals that are having a "disproportionate" share of outlier payments now because of the kind of things they're doing in the outpatient setting, which we think is the direction we want to go, it would start relocating those back into the hospital in order to get this protection. Then we would have set a policy up that was in the wrong direction.

So that's my concern. Maybe that's included in your reasons that you articulated and that you have in the paper but it's not said quite that way. I think that we should make sure that we're not setting policies that have that unintended effect. I don't know how big an effect that would be.

MR. HACKBARTH: Jack, but it may be that having an outlier is conceptually reasonable for some types of outpatient cases but not others.

DR. ROWE: I would say so. After I would say yes to that, then I would certainly say yes to certain types of cases. I think that outliers for some of the simple things, like putting a cast on, might not be costs or patient-specific characteristics. They might be provider-specific characteristics. I mean, if they're particularly bad at doing something and they have to redo it over and over again. Or it may be another way to pay for medical education or something else. I don't know what would be driving the outliers in some of these fairly simple things.

So I would say what we want to do is we want to point out certain.

MR. MULLER: Was that a [inaudible] -- slur there?

DR. ROWE: No, I'm just imagining. I'm remember when I was a resident, I kept doing it. You're going to run this play until you get it right. So I would pick some complex things or look at the last payments in the past and choose the most important ones.

The other comment I would make while I have the microphone is I would not support the idea of taking Bob's Ph.D. away. I think we might revisit his role as Vice Chairman of the Commission but not...

[Laughter.]

MR. MULLER: I'm also in favorite having an outlier policy. Remind me again, the loss on the patients was about the 15 to 17 percent range?

DR. WORZALA: You're talking about the margins?

DR. WORZALA: Yes.

DR. WORZALA: Yes, -15.

MR. MULLER: So to have a component, or whatever we called it yesterday, that on average has a negative margin of 15 percent, with all that caveats of Joe's about the cost allocation process, but still it's one in which there are considerable losses on average.

Secondly, in the example you gave of how the outlier works, even after the outlier payment in that particular case the hospital, the place was getting less than 50 percent of cost. So in a sense it mitigates some of the extreme losses but doesn't mitigate it very much the way the formula is calculated with that 2.5 times threshold and then the 45 percent of marginal cost. It's really a pretty modest payment for the wide variation in costs that could occur, probably due to acuity and other things that we're going to understand more fully.

So to both have a program area in which there are considerable -- let's say there's a pretty high negative margin -- and the outlier policy doesn't go very far towards mitigating that loss in extreme cases. So from my point of view, this is a pretty damp outlier and it doesn't do much mitigation, especially if we're in favor of limiting the number of APCs to which it applies and perhaps not have some of the more narrowly defined APCs put into outlier policy. That's even more reason perhaps to focus the outlier on the ones that have more bundling going on, that have more variation and more range.

The examples you gave in the document that you sent us I think was very well done. It does indicate that some of these APCs are a little closer to DRG bundles. And I think focusing on the ones that are a little closer to that makes a lot of sense.

And so if we could, as we elaborate on this work over the course of the year, to get a little bit more information on the ones that have the more variation -- I think that's when Joe was asking in his initial comments -- I think would be very helpful. But I think we should keep reminding ourselves this dampens very modestly a program in which we already have considerable losses. So it really doesn't -- unlike the inpatient outlier policy where there's some evidence that CMS has responded to that considerable margins can be achieved through the outlier policy, positive margins can be achieved through the outlier policy, this just dampens a pretty considerable loss. It doesn't really , it strikes me from the evidence we have, put certain of these APCs into a high margin.

To go back to Nancy-Ann's point about the growth, the grown again, as we've shown over the course of the last few years, is much more technology driven and utilization driven and so forth. I don't think the evidence is as clear yet, if there's evidence at all, that there's high margins per procedure on this, as opposed to a considerable increase in utilization. So that the 18 or 20 percent increases that are going on, I would suspect are more utilization driven rather than high margin per case driven.

MR. HACKBARTH: Ralph, help me out. I think of this is as a distributive issue. These dollars wouldn't disappear, they would go back into the base. So with regard to the overall average margin of hospitals for outpatient services, this is a neutral policy. Whether you have the outliers or not, or constrained or not affects the distribution of payments among types of hospitals, but not the overall margin.

MR. MULLER: Correct, but if in fact, if the outlier does what it's intended to do, which is act as an insurance policy on some cases in which there is extreme variation, then in fact

having some kind of appropriate payment for those cases I think is an appropriate distributional effect. And therefore, having some of those APCs or the patients in those APCs have some of fair approximation of costs, I think is a fair way of thinking about it.

Even though in some of these cases the provider may be losing 80 or 90 percent on that, and that's not a good policy to have to be losing at that level. Because even as I say, in the case that Chantal gave, they were still losing about 60 percent or so, a 60 percent loss. So to have APCs that are that far off coming closer to break even, I don't think is a good distributional policy to have.

I follow your point but the reason that we have outliers and have circuit breakers and so forth is to take into account the fact that they're still -- and since it's based on averages, there can be some considerable variation and there should be some accommodation for that variation.

MR. HACKBARTH: And I agree with that and I think that leads you to thinking about outliers in terms of the APCs where there is a potential for large variation in case costs.

MS. DePARLE: I just wanted to respond to that. Based on everything I've heard this morning, I'm not convinced there is such a strong rationale for an outlier policy here. If there is to be one, I think it should be more limited and specifying some dollar thresholds, I think that's what Joe and others have said here today. And I would hope if there's anything we can contribute to a policy that would help CMS to avoid the kind of problems that have occurred in the inpatient area, I would hope that we would do that.

I'm also troubled by the fact that we do not -- that this is not available in other settings, where these same procedures are being performed. And we have said before that we wanted to create a more level playing field. And so I like to be convinced that that's fair here.

DR. WORZALA: I just want to mention one thing that I didn't put in my presentation but was in the paper. In the proposal rule for 2004, CMS points out the case of the community mental health centers that provide partial hospitalization services. They did find pretty significant evidence that a subset of those providers were, in fact, gaming the outpatient outlier system. They found charges -- well, it ended up that a subset of providers received as much in outlier payments as they were receiving in their base payments for these services. Then they were finding that the charges for the services for some of these providers were actually higher than an inpatient psychiatric stay.

So there's potential on the outpatient side, and it apparently has been acted on by some providers. And CMS has responded by proposing to set a higher threshold for that particular set of providers than for hospitals because they felt like it was a sufficiently isolated case.

MS. BURKE: I agree with much of what Nancy-Ann has said, although I do fundamentally believe in an outlier payment policy. I think the nature of a reimbursement system that's based on

averages suggests that in fact there are legitimate variances that must be dealt with if they are extreme, which suggests that -- has been proposed -- I think it is not only a question of a threshold amount which puts an institution at risk but it is also the variance that exists in the individual cases that I think has to be tracked.

So I think we would be well guided to look at both what a threshold would be, that in fact is a significant risk, where there is in fact variation, going to Joe's early point, what can we track in terms of those particular instances where this is warranted and reduce substantially. I mean, to suggest that it ought to be applied to all treatment is crazy by the nature of what goes on in those settings.

The other question, however, is this question of whether it ought to apply outside of an institutional setting to non-hospital based programs. And I don't know that I know what the right answer to that is.

I do think we have to be worried about setting different incentives, which is something we've talked about repeatedly over the last couple of years, that depending on the setting we essentially -- by the nature of how we pay -- lead people in certain directions. Although I was quite concerned, I noted that description of the mental health provider was frightening in terms of what the risks might be.

But I do think there needs to be some analysis of whether or not it should legitimately apply, particularly if we're able to narrow the types of cases that are, in fact, where there are huge variances that we may be able to control that in an environment that's not in the hospital-based environment. So I think all of those things ought to drive us in terms of further analysis and whether we can narrow it down. But I do fundamentally think we ought to have an outlier policy.

DR. REISCHAUER: I basically agree with Nancy-Ann also on where we should go with this.

I was wondering whether we had any information about how private plans pay for outpatient procedures and whether they have outlier types of mechanisms or a payment system which in practice makes adjustments for acuity and other kinds of things?

The other comment that I'd make is looking at this outlier payments by hospital group chart, I wondered if we could do some more refined analysis here. Because the thing that leaps out at me is the proprietary line and the knowledge that few of those hospitals are major teaching, and many of them are in other urban locations.

And if you do your mental arithmetic here, you might find that the gap is really very, very large which then would raise a set of questions because of what we know about the inpatient abuses that have taken place with respect to outlier payments.

DR. WORZALA: I should note that charges are set for all payers by law and so you don't have a different charge for an refer ancillary service when it's provided on the inpatient side versus an outpatient side. So when you're talking about escalating charges, a lot of those charges apply on both sides of the line.

DR. REISCHAUER: Isn't the real question who pays charges? I mean, you know, Saudi princes?

MR. MULLER: The allegation in the inpatient was that some providers had doubled their charges overnight.

DR. MILLER: Also, with respect to Medicare, it's which services you choose to increase your charges on.

MR. MULLER: No, to take advantage of the cost of charge calculations.

DR. MILLER: Even if you have to charge it similarly, it's which ones you choose to set the charges high on, if you're trying to have an impact on Medicare. Although, in some of the stuff that went on, really the sense is that the charging practices that they were engaged in were actually to drive both Medicare and private pay outlier type policies.

MR. MULLER: Bob, the privates do have outlier circuit breaker-type policies. They are more inpatient focused than outpatient focused and they have different thresholds but they do exist.

DR. ROWE: You're referring to stop loss?

MR. MULLER: Yes. There's various kinds of circuit breakers. But I think one of the questions that we're starting with, to use the inpatient analogy, is when people inappropriately jack up prices 100 percent. I mean, one can make arguments that charges should go up two, three, four, five. It's a lot harder to say that when somebody takes over the hospital you have to increase the charges 100 percent, as some of people did and the stuff that hit the pass this summer. There's probably not much warrant for that, in terms of a cost structure, to increase your charges 100 percent.

Then given how some of the modifications that CMS has made in the inpatient policy, tries to take that into account. Also there was some room to play with the hospital-specific cost-to-charge ratio vis-a-vis the state cost-to-charge ratio. So there clearly gaming going on there.

I agree with Nancy-Ann, we shouldn't have policies that invite gaming that quickly and unfortunately, one shouldn't necessarily throw out the whole policy just because there might be some people who game it. And obviously, having cost-to-charge ratios does invite that kind of gaming to go on whether one does it by looking at settings in which charges blow up by some unreasonable number and how do you define unreasonable and so forth, might be one way of dealing with it. But certainly that was, I think, what happened on the inpatient side.

DR. ROWE: Can I ask Nancy-Ann a question? Do you find my concern just unpersuasive or you don't think it's -- you have so much more experience than the rest of us here in this about relocating stuff back into the inpatient in order to protect themselves on outlier side. You don't think that's going to be a problem?

MS. DePARLE: I guess, in looking at the data that Chantal has presented, we have now what 600 APCs? This is more granular than any other payment system we have now. And you start to wonder are we even really bundling anymore. I guess I just have some questions about where we're going with this in general.

DR. NEWHOUSE: But then there won't be much variance.

MS. DePARLE: And therefore I don't find it as compelling, Jack, that we need an outlier policy in this setting as I do certainly in the inpatient setting. I didn't say that I -- I just said I wasn't convinced. I don't find it is convincing, especially when we look at some of the examples that Chantal gave. Obviously, we have to look at all of them. And an example of setting a cast for $19, I hope she's going to tell us that she did not find any evidence that CMS paid outlier payments for that.

DR. REISCHAUER: But doesn't an inpatient one have a dollar threshold that's very high and so it eliminates virtually all of these.

DR. ROWE: It's a stop-loss.

MS. DePARLE: I was there when we implemented this, so perhaps I should have seen that then, but I'm just saying it seems to me clearly that we need some sort of threshold for this. I don't think, even if you find Jack's arguments more compelling even then I did, you would not say that it should apply to everything, I think. You didn't say that.

DR. ROWE: I didn't represent that.

MR. MULLER: There is a threshold in there.

MS. DePARLE: Not in the outpatient. That's the problem, so it could apply to this setting a cast APC for $19.

MR. MULLER: Well, 2.75, I'd call that a threshold.

MS. DePARLE: But that's a threshold of the payments. That's not a threshold of which things it should apply to. I guess I think that's what the outlier policy should be designed around.

MR. HACKBARTH: Nancy-Ann, what I hear you saying is if we do Joe's analysis and find for selected APCs that there is a lot of variation, you wouldn't be opposed to an outlier policy in those limited cases. But you want specific -- not just across the board.

MS. DePARLE: I would be interested in a dollar threshold, as well, although if we find -- I mean, it's quite interesting, at least to people at this table I guess -- if we found that for something like the example the Chantal used, the $19 procedure, there was that much variation, I would want to bring Karen and the equality people up here and say what's going on in some of these hospitals.

MR. HACKBARTH: We use variation and that's shorthand for variation beyond the control of the provider, so it's variation in the patient and the needs of the patient as opposed to just variation of what they're doing is ideally what we want.

MS. DePARLE: That's what we'd be looking for but I'd be very interested in knowing that, if that's the case.

MR. HACKBARTH: That's exactly the problem.

DR. WORZALA: I can just tell you, just as a cautionary tale, and I will certainly bring you back things that show the coefficient of variation by service. But as Bob pointed out, this is all dependent on the data that the hospitals submit. And so all of these motivations are in there.

And I will tell you that there are electrocardiograms where

the charges are $140 in my dataset and that will be picked up as part of the coefficient of variation.

So in theory, we think that a small bundle should have lower variability, but I don't know that that's going to show up in the data because of all the motivations that are in play right now.

MR. SMITH: Very briefly, I found Jack's argument persuasive but persuasive at a very high level, which seemed to me that there ought to be a pretty high dollar threshold and perhaps some APC limitation. You're going to have distributional data both on amount and APC. That will give us some sense of how to constrain it. But it does seem to me that we have an access issue and we have a site of treatment issue if we don't have an outlier policy and there's no particular reason to do that if we can figure out how to narrow the universe to which it applies.

And I suspect that also argues for a similar outlier policy in other outpatient settings. I doesn't seem to me we can argue that we're concerned about shifting treatment back into the hospital if we get rid of the outlier policy but we're not concerned about shifting stuff back into the outpatient department if we don't apply the outlier policy more broadly. So narrow it and expanded it.

DR. ROWE: Let me give you an example of what I was thinking about, just to be specific. I think it was at Duke University where some really fabulous guys developed an outpatient bone marrow transplant program, which is just a terrific idea because these patients are at risk for infection. You want to keep them out of the hospital. When you put them in the hospital you have to create an environment around them which makes believe they're not in the hospital, et cetera, et cetera. And I may have the details wrong, but I think it was at Duke. And I think their results are excellent.

The last thing you want to do is stem that kind of innovation because these are very sick patients and they may have some whatever, and have a bad experience and have the hospital say look, we can't afford this anymore.

So I'm thinking of this very high end stuff and I don't know what the threshold is, but I'm trying to foster innovation is what I think we need to do with the policies. That's where I was coming from.

MS. DePARLE: I agree and I think I remember that.

Remember, there's also an issue though, and Chantal mentioned this, as to which procedures are appropriate for the outpatient setting and that's a separate issue. You talked about it a little bit in the paper. We didn't talk about it here.

DR. ROWE: [Off microphone.] We should let tomorrow's doctors decide that.

MS. DePARLE: I was going to say my view is that CMS has expanded it, perhaps not enough. Perhaps, both in the hospital outpatient setting and in the ASCs, there should be more flexibility there. That's a separate issue.

But also remember we're not talking about taking these dollars away from the outpatient hospital setting. We're simply saying, at least it's my belief, that they should be targeted towards truly appropriate cases. And what we're talking about

here is defining those. And I just don't think that they have been defined adequately so far.

MR. HACKBARTH: I have Joe and then Ray, and then I think we need to move on.

DR. NEWHOUSE: I certainly agree with Jack's intent, but to the degree there is an issue it's a much bigger issue than outliers. That is, there could be no variation within each APC, in which case there would be no need for an outlier scheme. But there could be quite different reimbursement for the outpatient setting than the inpatient setting. In which case payment policy could conceivably influence site of care. Whether it did or not is another matter.

Maybe at some point staff wants to look at the different payments for things that could go back and forth. We've seen the practice expense on the office, the ASC, and the outpatient department and the non-neutrality there. And we've seen some non-neutrality in the post-acute side. Maybe we should also look at it here. I don't recall seeing any data like that for inpatient/outpatient.

DR. STOWERS: I think I'm kind of saying what Joe was saying, but Jack, I see your example more as setting an appropriate APC for outpatient bone marrow rather than a variance between the cost of doing that from one patient to another.

DR. ROWE: Sure.

DR. STOWERS: I think that's where the innovation has to come, as in quickly bring in new APCs to cover new procedures. But I think it's important in this chapter not to get that confused.

DR. ROWE: Okay, I accept that. I think that's a good addition. I do think that when you're innovating, the variability in your experience is greater and it gets really hard, until you have a lot of experience, to set the right price. And so you're making it up as you going along. You're innovating and you really don't know.

So I agree with you that if you get the right price, then if you get enough cases and a reasonable variation around it, everybody will be okay. But early on you're putting some people at risk and that was really what I had in mind.

MR. HACKBARTH: Thank you, Chantal.