

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
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Washington, D.C.

Thursday, December 4, 2003
10:13 a.m.*

COMMISSIONERS PRESENT:

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MR. HACKBARTH: I'd like to welcome our audience.
Please take your seats.

Let me make a few comments to help set the stage for today's and tomorrow's session. As you may have heard, there have been some significant legislative developments in the Medicare program recently, so recently in fact that it poses a challenge to the Commission on how to proceed with its work.

Obviously, the legislation has very large impacts on the program, including some of the issues on our immediate agenda. So let me try to explain how we're going to deal with that.

First of all, we will not be addressing the Medicare reform legislation in its entirety in this year's reports. At some point in the next year we will try to put out a document that explains some of the issues that we think arise for the program and for the Commission out of the legislation and will serve as a bridge, if you will, to our work in the next cycle beginning in the fall of 2004.

Having said that, pursuant to our existing mandate we need to take up a number of specific provisions in the

1 legislation just to complete our normal cycle of work for
2 this year. As we do that, we will reflect the reform
3 legislation in some important respects, one of those being
4 as we address -- make recommendations about the appropriate
5 updates for the various provider sectors, the analysis that
6 will be presented by staff over the next couple days will
7 include the impact of the reform legislation.

8 So this month and next month we are making
9 recommendations for fiscal year 2005. As you hear the staff
10 discuss financial analysis, that analysis will include the
11 impact of all of the legislative provisions affecting
12 updates through 2004 and all of the distributive -- what we
13 refer to as distributive provisions that affect, for
14 example, rural hospitals differentially than urban
15 hospitals, all of those that are scheduled to be accompanied
16 through 2005. The one piece and will be omitted from that
17 staff analysis is the legislated update for 2005. And the
18 reason, of course, that's the questionable before the
19 Commission, so we don't include that.

20 In keeping with our approach of last year, the
21 staff will be presenting a series of draft recommendations
22 on update factors and a variety of other issues. Those are

1 draft recommendations that I have developed along with the
2 staff. They are a starting point for the discussion of the
3 recommendations. They are not an end point, but they are
4 draft recommendations that I have developed.

5 I think those are the key points to get us
6 started. The first item on our agenda for today is dialysis
7 services. Nancy.

8 MS. RAY: Thank you, Glenn.

9 Recall that our update framework first considers
10 the question of whether current Medicare payments are
11 adequate and then considers the second question of whether
12 payments should change in 2005, the next payment year. So
13 let's proceed and try to answer these two questions for
14 outpatient dialysis services.

15 To assist payment adequacy, your mailing material
16 includes an analysis of six factors. Some are beneficiary
17 focused and some are provider- focused.

18 The first factor we looked at is beneficiaries'
19 access to care. Here the evidence suggests that
20 beneficiaries are not facing systematic barriers in
21 obtaining needed care. Throughout the year, we monitor the
22 literature, dialysis magazines, and Internet websites to

1 look at any potential access barriers that may be coming
2 along during the year.

3 For this year we particularly -- some have raised
4 concerns that facilities may be exiting areas that are
5 located -- facilities located in lower income areas. So we
6 took a look at that this year. What we found is that this
7 does not appear to be the case. The two biggest factors
8 that seem to reflect closures are whether the facility is
9 non-profit and whether the facility is hospital-based. We
10 looked at the proportion of facilities remaining open in
11 HPSAs and there was very little difference, in rural areas
12 very little difference, and we also looked at --

13 DR. NEWHOUSE: [off microphone.] What exactly
14 does this mean? Does this mean that 50 percent of the
15 hospital-based facilities closed in a year?

16 MS. RAY: No. This means that of the facilities
17 that closed.

18 DR. NEWHOUSE: All right.

19 MS. RAY: The fact that we found that the non-
20 profit and hospital-based are more likely to close is
21 consistent with our analyses that we have conducted last
22 year and the year before last. What makes this analysis

1 different is that we looked at whether or not the facility
2 was located in a HPSA. We've looked at the proportion of
3 facilities in rural areas and that has remained constant.
4 Roughly 25 percent of all facilities are in rural areas over
5 the last five years.

6 This is the additional new information that we
7 looked at this year, looking at the facilities that opened
8 that remained in business versus those that closed. Again,
9 we see very little difference based for lower income areas
10 and areas based on ethnicity and race.

11 Moving right along now to the second factor, we
12 looked at providers' capacity to treat patients. And here
13 we conclude that capacity appears to meet demand. This
14 graph compares the growth in the number of in-center
15 dialysis hemodialysis stations to the growth in the patient
16 population.

17 Our framework, or the third factor that we looked
18 at the growth of the volume of services. Here increasing
19 volume of services could suggest that payments are at least
20 adequate.

21 With that in mind, total dialysis patients have
22 been increasing by about 6 percent per year between 1996 and

1 2001. Dialysis payments have also increased by 6 percent
2 per year during this time period, from \$2.4 billion to \$3.3
3 billion. Separately billable drugs, erythropoietin has
4 increased roughly about 12 percent from \$809 million to \$1.4
5 billion. And other injectable drugs show the greatest
6 growth, growing by about 25 percent per year from \$281
7 million to \$877 million.

8 Moving along now to our fourth factor that we
9 looked at to assess payment adequacy, we looked at quality.
10 It's continuing to improve for some measures. We used CMS's
11 clinical performance measures that show improving dialysis
12 adequacy, improving anemia status. Again, for dialysis
13 adequacy and anemia status as well as nutritional status, we
14 have data now going back from 1993.

15 There has been little change in beneficiaries
16 nutritional status and this focuses -- this is partly due to
17 CMS's coverage policy on some of the nutritional
18 interventions. They have a restrictive coverage policy for
19 the use of those interventions.

20 Finally, CMS is now starting to collect clinical
21 performance measure data on vascular access care. There was
22 some small improvement in vascular access care, and my

1 understanding is that the networks -- that's the QIOs -- for
2 dialysis facilities are engaging in a quality improvement
3 project aimed to improve vascular access care.

4 Many may be aware of a recent GAO study that
5 discussed dialysis quality. It was released last month.
6 And the GAO study focused on quality assurance; that is how
7 well facilities are meeting Medicare's conditions of
8 coverage. The conditions of coverage are Medicare's
9 baseline standards, quality standards. It also commented on
10 how well CMS and the states are conducting their survey
11 efforts.

12 GAO raised concerns for all three parties,
13 facilities, the CMS, and the states. And in fact, made six
14 recommendations to improve the quality assurance process,
15 three of which MedPAC made back in June of 2000. Those
16 three were to improve the frequency of inspection, to
17 implement intermediate sanctions, and to publicly release
18 the results of the survey and certification efforts on the
19 publicly available Dialysis Compare website.

20 At the end of my presentation, I'd like to come
21 back to quality and talk about other ways for Medicare to
22 consider to improve dialysis quality.

1 This leads us to the fifth factor, access to
2 capital. Access to capital appears to be sufficient. We
3 base this on the reports from financial analysts and we also
4 base this on the growth over the last 10 years of for-profit
5 facilities. It seems to be still an attractive place for
6 for-profit facilities to build facilities as well as acquire
7 existing facilities.

8 With that in mind, one of the four major chains
9 just announced on Monday their intent to acquire non-profit
10 facilities in the Midwest, picking up about 260 patients.

11 DR. ROWE: [off microphone.] Nancy, while you're
12 on that point, could you indicate whether this growth in
13 for-profit facilities has been largely conversion of not-
14 for-profits, or is this establishment of new facilities?

15 MS. RAY: That's a good question.

16 DR. ROWE: [off microphone.] Because many
17 hospitals find that it makes more sense for them to
18 basically sell their facility to a for-profit and then
19 management has a lower cost of goods, established management
20 programs, as long as the hospital's patients have access and
21 doctors have access. And then the place has access to
22 capital and it can renovate because the hospital hasn't been

1 able to renovate the dialysis unit because it doesn't have
2 any access to capital, et cetera, et cetera.

3 So I was just wondering about that conversion.

4 DR. MILLER: [off microphone.] Nancy, I thought
5 we had some discussion of this at one point when we were
6 talking some of the language in the report. I was asking a
7 question about growth at the expense of.

8 MS. RAY: Yes, I do remember that discussion.
9 Yes.

10 DR. MILLER: I don't know if it's was a one for
11 one, but I thought you said at that time that the growth for
12 the non-profits is definitely --

13 MS. RAY: Right. Clearly, some of the growth of
14 for-profits has been those chains acquiring non-profit,
15 independent non-profit and hospital-based facilities.

16 DR. ROWE: [off microphone.] Like you said, in
17 the Midwest.

18 MS. RAY: Right, exactly. What I can't give you
19 right now is the exact number, the exact proportion, whether
20 it's half new facilities and half acquiring old. I'll have
21 to get back to you with that.

22 DR. ROWE: [off microphone.] I think it would be

1 interesting because one of the measures we use of access is
2 whether there's new entrance into the market place in terms
3 of new facilities and access to capital.

4 DR. REISCHAUER: But we know that there are new
5 facilities because there's been tremendous growth in the
6 number of facilities.

7 MS. RAY: And facilities. There has been a net
8 increase.

9 DR. REISCHAUER: I'm looking at the paper that
10 says facilities and there's been a 76 percent growth over
11 the last decade, so that's not chicken feed.

12 DR. ROWE: [off microphone.] Right. I accept
13 that. I was thinking over the last couple years is whether
14 it's gotten to steady state or whether it's continuing to
15 increase. That was my question.

16 DR. REISCHAUER: But if we know that the total
17 number of facilities is growing or stations, or whatever we
18 want to measure it by, is growing along with the demand,
19 then do we care about the composition?

20 DR. ROWE: [off microphone.] No, I don't think we
21 care from a policy point of view.

22 DR. REISCHAUER: For business opportunities.

1 DR. ROWE: [off microphone.] No. No. Sorry to
2 interrupt. More sorry that you know.

3 MS. RAY: Not a problem.

4 So moving right along, that was our fifth factor,
5 access to capital. And that leads us to our final factor,
6 payments and costs for 2004.

7 Let's take a minute and talk about this graph.
8 First of all, you'll see that we have three years of data
9 reported here, 1999, 2000, and 2001. We unfortunately don't
10 have 2002 data to show you, and that is because we had a
11 very small sample, we have a very small sample right now of
12 cost reports in the data that CMS makes available. Roughly
13 we only have 40 percent of facilities cost reports in 2002.
14 That compares to about 91 percent in 2001. So that is why
15 we don't have the more recent year available. Hopefully,
16 there will be one more update to CMS's database on cost
17 reports and who know, maybe we'll get lucky.

18 Next, you'll notice that there's two lines, red
19 line and a yellow line. As you recall from last year, we
20 analyzed 1996 cost reports. In 1996 the FIs did an
21 extensive audit of the cost reports of freestanding dialysis
22 facilities. Roughly about two-thirds of the cost reports

1 were reopened and settled with an audit.

2 So the red line reflects adjusting cost to reflect
3 the results of the audit. Overall, what we found in
4 comparing 1996 costs from cost reports before they were
5 audited to after is that reported costs were roughly 96
6 percent of allowed cost. So what we did here is we adjusted
7 cost to reflect the 96 percent that was allowable, payment-
8 to-cost ratio. So what you're doing is you're reducing the
9 denominator that will increase your payment-to-cost ratio.

10 So the red line includes the audit adjustment and
11 the yellow line does not include the audit adjustment for
12 each of the three years that we have presented.

13 Also recall, we did this audit adjustment last
14 year and ProPAC, many years ago, also did an audit
15 adjustment back in the late '80s. There they found that
16 reported costs were 88 percent of allowable cost back then,
17 from the late '80s.

18 So here you'll see a payment-to-cost ratio in 2001
19 of 1.03. That's without the audit adjustment. That's
20 roughly, for you margin people, a 1.8 percent margin. And
21 including the audit adjustment, the payment-to-cost ratio is
22 1.06, which is a 4.4 percent margin.

1 I'd like to talk about the downward trend between
2 1999 and 2001 and what explains this trend. Payment was
3 increased in 2000 and 2001 by 1.2 percent and 2.4 percent.
4 But at the same time, Amgen raised the price of
5 erythropoietin by 3.9 percent in each of those two years.

6 In addition to that, providers costs spiked,
7 particularly between 2000 and 2001, by 5.5 percent. The two
8 areas that rose were labor costs and the administrative and
9 general costs that are reported on the cost reports.

10 DR. ROWE: [off microphone.] And labor costs were
11 mainly nursing costs?

12 MS. RAY: The labor costs reflect nurses,
13 technicians, LPNs, dietitians, as best of my understanding.
14 It includes salaries and it includes benefits.

15 DR. ROWE: [off microphone.] You don't know where
16 the increase is?

17 MS. RAY: No, it does not break it out by the
18 specific labor component, no. It's just the one category.
19 Unfortunately, we don't have a break-out for the
20 administrative and general expenses, either. My impression
21 from the industry is that some of that cost growth was due
22 to liability increases and malpractice increases there, as

1 well as utilities.

2 So estimating from the 2001 point -- I guess I'd
3 like to make the point that I presented payment-to-cost
4 ratios and I'm also presenting margins to be consistent with
5 the other sectors, for example, in the hospitals and SNFs
6 and home health you usually hear margins not payment-to-cost
7 ratios. And a margin, just for the audience's sake, is
8 payments minus cost divided by payments, which is roughly
9 the percent of revenue the provider is keeping, our rough
10 estimate of that.

11 MS. DePARLE: And it's just Medicare?

12 MS. RAY: It is just Medicare.

13 DR. REISCHAUER: Nancy, what was the takeaway from
14 your description of what happened between 1999 and 2001, but
15 looking out into the future? That you think these payment-
16 to-cost ratios are going to level off?

17 MS. RAY: Okay, that leads me to my next point.

18 DR. REISCHAUER: Okay, I'm your straight guy.

19 MS. RAY: Thank you.

20 So what we did is we took our 2001 point and we
21 proceeded then to estimate 2004 payments and cost. We do
22 that by inflating costs by the market basket. The payment-

1 to-cost ratio then, including the audit adjustment, for 2004
2 would be 1.02. That would be our estimate. That represents
3 a 0.7 percent margin. So this presumes continued increases
4 in cost based on the market basket, if that answers your
5 question.

6 MR. MULLER: Along the line of Bob's question, I
7 seem to remember two years ago we were looking at cost
8 estimates that people were saying the costs were going up
9 beyond the marketplace indicators that we had. So this
10 would kind of confirm that the way the costs finally came
11 in, it came in above the estimates that we were making at
12 that time of what the costs would be. Is that fair? That
13 the actual costs, now that we've seen them two years later,
14 are higher than the costs that we had anticipated at that
15 time?

16 MS. RAY: It's your question are the actual costs
17 higher than the market basket? Than the Commission's market
18 basket estimates in previous years?

19 MR. MULLER: That's another way of saying that,
20 yes.

21 MR. HACKBARTH: Another way, perhaps of asking it
22 is if we went back and look at what we projected for this

1 year, how did our projection for 2001 compare with the
2 actual result? Now that we have real data.

3 MS. RAY: I would like to get back to you on that,
4 if I could.

5 MR. HACKBARTH: In rolling forward from the actual
6 data, you said you used market basket or was it market
7 basket minus a productivity factor.

8 MS. RAY: Market basket less a productivity, yes.
9 Thank you for the clarification.

10 MS. DePARLE: And when you say market basket,
11 there's a CMS market basket and then --

12 MS. RAY: Right, exactly.

13 MS. DePARLE: I've never understood why we have a
14 separate one? Why we don't just agree with CMS.

15 MS. RAY: We had a separate one because CMS just
16 developed their market basket for dialysis services. It was
17 just released in May of this year.

18 MS. DePARLE: So we had one before.

19 MS. RAY: Ours is first.

20 DR. REISCHAUER: [off microphone.] The question
21 is why did they have one?

22 MS. DePARLE: They were told to develop one. So

1 what are we going to do? Are we going to use theirs or are
2 we going to use ours?

3 MS. RAY: I was going to talk about that later but
4 let me go ahead and address it. First of all, if you use
5 CMS's market basket to project out costs to 2004, just to
6 let you know that the payment-to-cost ratio in 2004 would be
7 estimated at 1.01. That's the first thing.

8 I think the second thing is, of course the
9 Commission can talk about whether or not to just go ahead
10 and adopt the CMS market basket or we can continue to use
11 both and compare the two. BIPA required the Secretary to
12 develop the market basket for dialysis services.

13 I think over time, as CMS goes to a broader
14 bundle, and then the market basket is going to have to be
15 revised to account for those additional services, that might
16 be one factor in leading us to think about using the CMS
17 market basket.

18 Your mailing materials included some historical
19 data in how well CMS's market basket compared to MedPAC's.
20 Both are pretty close, but we can talk about this a little
21 bit later.

22 DR. REISCHAUER: They aren't as close as the table

1 suggests though, because you have the MedPAC market basket
2 in every year rising faster than the CMS market basket. And
3 yet, averaged over a five year period, they are the same.
4 There must be a typo in the table.

5 MS. DePARLE: I'd be interested in qualitatively
6 can you describe what the differences are and why we would
7 choose ours versus theirs.

8 MS. RAY: Sure. The differences are when ProPAC
9 first developed the Commission's market basket, they used
10 indices from the home health, SNF, and hospital PPS market
11 baskets.

12 So for example, the easiest example I can give you
13 is in the MedPAC market basket there are four main
14 categories: labor, other direct costs, capital, and
15 administrative and general. For the labor component, what
16 is used is they used the home health labor index, they use
17 the SNF labor index, and they use the hospital PPS labor
18 index. And each is weighted by one-third.

19 So it's a mixture of -- for the other categories
20 it's a little bit more complex, but it's a mix of the use of
21 utilities from SNFs and so forth, to come up with the
22 Commission's market basket.

1 CMS, on the other hand, uses eight categories, not
2 four, I believe. And they pull out the indices from either
3 using the ECI, the PPI, and I'm sorry, I forget the third
4 one. So they're using, for example, the labor -- to
5 estimate the labor costs for all health care workers from
6 the ECI, for example.

7 I can get back to you in the January mailing
8 materials with more detail about the comparison of the two,
9 that will help you think about this issue more closely.

10 DR. NELSON: Nancy, what are the implications of
11 the consistent difference between audited and unaudited?

12 MS. RAY: Excuse me, I'm sorry?

13 DR. NELSON: What are the implications of that
14 consistent difference, between audited and unaudited? What
15 does that mean?

16 MS. RAY: What we did in each year, in 1996 we
17 found that the reported costs that facilities put down on
18 their cost reports once they were audited, that CMS
19 disallowed basically 4 percent. So reported costs were 96
20 percent of allowed cost.

21 So what I've done here is made an adjustment to
22 cost in each of the years, taking roughly 96 percent in each

1 of the years. So that's why between the two lines there's
2 that same three percentage point difference.

3 DR. ROWE: [off microphone.] It's not a typical
4 accounting audit. It's a revision of what's acceptable.

5 DR. NELSON: I got it. Was the standard of
6 variation pretty narrow or pretty broad? This is a
7 consistent number that represents the difference. And I
8 guess I would ask whether or not there were a substantial
9 number of outliers in which that difference was much
10 different from the average?

11 MS. RAY: I can't answer that question for you
12 right now. But what I can answer is that about two-thirds
13 of facilities had a substantial decline from their reported
14 costs to their allowable costs. I'd have to get back to you
15 to answer your more detailed question.

16 MR. HACKBARTH: We're doing an excellent job of
17 anticipating issues, some of which I think are planned for
18 later parts of Nancy's presentation. Could I suggest that
19 we let her get her presentation out and then we'll take
20 commissioner questions? I think that will be a more
21 efficient way to proceed. So why don't you go ahead, Nancy.

22 MS. RAY: I think we're finished with this chart.

1 So just in summary, the analysis, just a gentle
2 reminder of the first five market factors suggest no
3 systematic problems in accessing care, that there is
4 sufficient capacity to treat patients, and services are
5 growing. There is improving quality on some measures and
6 providers seem to have sufficient access to capital.

7 That leads us to the second part of our update
8 framework, looking at what kind of cost changes can we
9 expect in 2005.

10 Here again, the one major factor that we consider
11 is the change in input prices between 2004 and 2005. As
12 we've already discussed, we now have two market baskets,
13 Commission's and CMS's. The Commission's market basket
14 estimates the increase in providers costs at 2.3 percent.
15 CMS estimates that cost growth to be 2.9 percent.

16 We also look at other factors that may affect
17 providers costs between 2004 and 2005. One of those is cost
18 increasing and quality enhancing medical advances. Here,
19 based on our review of the literature, we believe that most
20 of these advances will come in the way of separately
21 billable drugs.

22 And then find that the other factor that we do

1 consider is the productivity growth. Our update framework
2 reflects our expectation that, in the aggregate, providers
3 should be able to reduce the quantity of inputs required to
4 produce a unit of service while maintaining service quality.
5 We use a 10-year economy-wide multi-factor productivity
6 growth and that is currently estimated at 0.9 percent.

7 So putting together the increase in input prices
8 less the adjustment for productivity improvement, that would
9 result, using MedPAC's market basket, in a 1.4 percent
10 increase to the payment rate for the composite rate
11 services. Using CMS's market basket, that would result in a
12 2 percent increase.

13 As a reminder, current law increases composite
14 rate payments in calendar year 2005 right in the middle, by
15 1.6 percent.

16 So that leads us to our first draft
17 recommendation, that the Congress should maintain current
18 law and update the composite rate by 1.6 percent for
19 calendar year 2005. The spending implications of this are
20 none, because it's already in current law. And for
21 beneficiary and providers it would increase the composite
22 rate for providers. And for beneficiaries, maintain access

1 to quality care.

2 MR. HACKBARTH: For the benefit of the audience, I
3 should say that although we will discuss draft
4 recommendation at this meeting, the actual voting on
5 recommendations occurs in January.

6 Any questions or comments?

7 MR. MULLER: If we can go back to your slopes of
8 the payment of costs. I noticed in the material you sent
9 out ahead of time that it looks like the costs in 2000,
10 which is the last year that we have the costs on, went up
11 about 5.5 percent over the year before. Our market basket
12 index was about 3.8, so about one-half higher.

13 If that is likely to occur in '02 as well, because
14 a lot of things were going on in '01 in terms of staff
15 shortages, nurses, et cetera, blood costs, those kind of
16 things that were probably still going on in '02.

17 Does that mean is it likely that as we get the '02
18 and '03 final estimates, that we're likely to be below 100
19 percent of payment-to-cost?

20 MS. RAY: Again, without a larger sample of
21 facilities with cost reports for 2002, I just don't -- you
22 know, at this point can't estimate what the change -- how

1 the slope of costs will go.

2 MR. HACKBARTH: Can I ask a related question?
3 Earlier you gave us a projection of the margins for '04, and
4 it was less than 1 percent, .7 percent or something like
5 that.

6 MS. RAY: Right.

7 MR. HACKBARTH: That involves a projection of
8 costs and revenues out into the future. On the revenue
9 side, is the assumption just the increases in the composite
10 rate? Or how do you factor in the growth and the use of the
11 drugs outside the composite rate? Since that's a big part
12 of the profitability of the business.

13 MS. RAY: Sure, absolutely. That's a good
14 question.

15 That's where our estimate, I think, conservatively
16 estimates what the payment-to-cost ratio is in 2004, because
17 we don't adjust for the increasing volume of separately
18 billable services, which as you've already seen has gone up
19 considerably since 1996.

20 DR. REISCHAUER: That's 40 percent of the total,
21 if I remember your analysis.

22 MS. RAY: That's 40 percent of the total, that's

1 right.

2 DR. REISCHAUER: And we're saying that it doesn't
3 change.

4 MS. RAY: And it doesn't change, that's right. If
5 you think it would change -- if you wanted to increase it
6 between 2001 to 2004 based on the annual growth rate, it
7 would be roughly probably increasing the proportion from 40
8 to roughly 43 or 44 percent of payments.

9 DR. REISCHAUER: But there's a huge margin, we
10 think, on that.

11 MS. RAY: There is a large and positive margin on
12 that, yes.

13 DR. REISCHAUER: So it affects really the way we
14 view this whole thing but we aren't making a guesstimate of
15 how much.

16 MS. RAY: I could go back and do that.

17 DR. REISCHAUER: No, I'm just reflecting on how
18 worried should we be about this downward sloping line. And
19 the answer is not as much as one would think.

20 MS. RAY: Right, because we hold volume of
21 services constant, this is -- like I said -- a conservative
22 estimate.

1 MR. HACKBARTH: I think it would be helpful if
2 fore the January discussion we could have a sensitivity
3 analysis or something that shows the revenue side, which
4 might be changing there, as well as the issue raised by
5 Ralph about the trend on the cost side.

6 MR. MULLER: If we're doing our two-stage test and
7 let's say if the costs, in fact, are accelerating more than
8 our past indices, it's likely that we might be below the
9 payments on this before the drug analysis that Bob has asked
10 for, that we may -- if the payment ratio is less than 100
11 percent, then the question is does that kind of touch the
12 question of adequacy or not?

13 MR. HACKBARTH: In fact, if we just look at the
14 composite rate services only, the ones covered by the
15 composite rate, I think we're already below 100 percent.

16 MS. RAY: Yes, you are.

17 MR. HACKBARTH: That is offset by the very
18 substantial profits earned on the non-covered, or the
19 services outside the composite rate.

20 MS. RAY: That's correct.

21 MR. HACKBARTH: That's the piece that's been
22 growing. So understanding that part of the projection, I

1 think, is as important as understanding the cost trend.

2 Other questions or comments?

3 DR. WOLTER: I was just looking at the data on
4 Table 3 that had some things like sessions per station,
5 total treatments per employee, percentage of LPNs,
6 percentage of RNs. And I'm thinking about this productivity
7 adjustment which I know is a discussion point right now, not
8 only in dialysis but in other sectors.

9 Those would possibly be some indicators, perhaps
10 not outstanding ones, but some indicators of is there in
11 fact some track record of productivity increases. And I'm
12 wondering if dialysis would be a place to start looking from
13 year to year at some indicators that might help us
14 understand, in fact, are productivity changes from year to
15 year current because I think there's some controversy about
16 that issue and how easy is it to do.

17 In this particular set of data, if you look from
18 2000 to 2002, there are a couple of things there that in a
19 high-level way might suggest some productivity improvements
20 although 2001 went in the other direction.

21 It's just a thought.

22 MR. MULLER: Triggered by Nick's comment, dialysis

1 is always more of a focused factor than probably other
2 things we look at. So insofar as some people have been
3 touting that as a way of getting more productivity in health
4 care. It would be useful to try to take a crack at Nick's
5 question.

6 MS. DePARLE: At one of our last sessions, when we
7 talked about this, we spent some time talking about the
8 medical interventions, and I remember specifically
9 nutrition, that were not covered by composite rate. And I
10 was persuaded that we should try to do something about that.

11 DR. ROWE: I think we're going to get to that.

12 MS. DePARLE: Am I jumping ahead again?

13 DR. ROWE: We're going to get to rewarding quality
14 based on these measures in the next presentation.

15 MS. DePARLE: Good, I hope we will.

16 DR. REISCHAUER: I think Nick's focus is an
17 interesting one and I glanced at that table and thought
18 whoa, not much productivity here. But then I looked at
19 treatments per employee, which would be a crude measure.
20 And it actually increased by 3.9 percent over the two-year
21 period. In other words, well above -- we're using total
22 factors as opposed to labor factor productivity.

1 But also, one wonders when we're considering
2 productivity in this sector, what is the appropriate measure
3 of output? And it's quality adjust treatments. And we have
4 some measures that quality has improved.

5 Of course, we want to reward people for that
6 improvement in quality. We don't want to take away from
7 them, in a sense. So it's a complex issue, I think, for us
8 to grapple with because what we want is to provide the best
9 care that's available at reasonable prices.

10 MS. RAY: Right.

11 MR. HACKBARTH: We've had several comments
12 raising, I think, important and very legitimate concerns
13 about are we perhaps being too aggressive here in light of
14 the cost trends and declining margin and the like.

15 The other piece of the picture, or another piece
16 of the picture, is that when we do our analysis of adequacy
17 we don't look only at margins. Here we have an industry
18 where there seems to be a continuing influx of investment by
19 for-profit companies that presumably see this as a good
20 business opportunity. So it's a complex picture.

21 Do we want to move on to the other recommendation,
22 Nancy?

1 MS. RAY: Yes.

2 I promised earlier that we'd be drilling down a
3 little bit more about quality of care. As I've already
4 discussed, GAO and patient organizations continue to raise
5 concerns about dialysis quality.

6 Recall that Medicare right now uses I would say
7 three levers to try to maintain and improve quality. One,
8 the quality assurance standards. Two, quality improvement
9 efforts undertaken by the networks. And three, the publicly
10 reporting of data both on the Dialysis Compare website,
11 which is a facility level website that provides outcome
12 information by facility, as well as CMS's clinical
13 performance measure project.

14 I would suggest that there may be a fourth lever
15 for Medicare to think about to try to improve quality, and
16 that would be using quality incentives to improve outpatient
17 dialysis care. Recall that the Commission expressed an
18 urgent need to improve quality in our June 2003 report and
19 endorsed the idea of the use of linking payments to quality.
20 The outpatient dialysis sector is a ready environment for
21 doing so.

22 In the June of 2003 chapter, the Commission

1 included four criteria to think about using quality
2 incentives for a given sector. The first criteria: are
3 there evidence-based measures available. The answer to that
4 for dialysis services is yes. The National Kidney
5 Foundation has spent many years in developing evidence-
6 based measures with providers, facilities, physicians and
7 nephrology nurses, and we have evidence-based measures for,
8 of course, dialysis adequacy, anemia status, vascular access
9 management, nutritional management, as well as a new one
10 related to bone disease.

11 The second criteria questions whether providers
12 can improve upon these measures. Again, I think the answer
13 to than for outpatient dialysis sector is yes. Since 1993
14 we've seen that providers can improve upon dialysis adequacy
15 and anemia status. More remains for those two indicators
16 and now there's new indicators related to bone disease as
17 well as nutritional management.

18 The third question is are there data available to
19 risk adjust measures? Here again, the answer is yes. When
20 a patient first becomes eligible for the ESRD program, the
21 facility is required to fill out a medical enrollment form
22 the 2728 form. Here we have comorbidities at ESRD

1 incidents. And those data are collected electronically and
2 maintained in a nice computer database. We also, of course,
3 have access to all beneficiaries' Part A and Part B claims
4 to supplement the medical evidence data.

5 And then the fourth question is are there systems
6 in place to collect data? And again, here the answer is
7 yes. Right now CMS collects adequacy of dialysis
8 information and hematocrit status on facilities outpatient
9 dialysis claims, on the claims submitted by outpatient
10 dialysis facilities for dialysis and for Epo. There's also
11 been an ongoing effort to electronically link facilities to
12 the networks and CMS for improved data collection.

13 So your mailing materials included other key
14 design issues that would need to be considered when
15 implementing quality incentives for this sector. The first
16 question is which providers. And here both facilities and
17 physicians, it's a partnership and both together work to
18 improve beneficiaries quality. The actions of both parties
19 affect patients quality of care. Recall that physicians
20 caring for dialysis patients receive a monthly capitated
21 payment. So they are seeing -- under the new revision to
22 the fee schedule, physicians seeing dialysis patients will

1 be seeing the patient at least once a month.

2 The second question is how should providers be
3 rewarded? Here we looked at the new ESRD demonstration
4 project, which rewards providers both based on improvements
5 within the facility as well as whether or not their level
6 exceeded a national target. That, to us, seemed like a
7 reasonable and fair approach to do that. In the
8 demonstration, a small set-aside of payments are used. And
9 here we think that could be roughly 1 to 3 percent of
10 payments.

11 For dialysis facilities anyway, total payments
12 from dialysis, erythropoietin and other injectable drugs
13 averaged roughly about \$2.8 million in 2001.

14 The next question asks how should quality be
15 measured? Again here, we've discussed some of the measures
16 already, dialysis adequacy, anemia status. CMS does not yet
17 have a clinical performance measure for bone disease, but
18 the National Kidney Foundation, like I said, has developed a
19 clinical guideline and CMS could readily use that to develop
20 a clinical performance measure here.

21 I raised the issue about the need risk adjust.

22 And I just wanted to mention here that our June 2003

1 analysis of dialysis quality and providers cost also
2 included many case-mix variables from the medical evidence
3 form and did show that quality is related to case-mix. So
4 that would be a very important factor in implementing
5 quality incentives.

6 I guess I'd just like to also just reiterate that
7 CMS and its contractors are well versed at developing and
8 measuring dialysis outcomes and, in fact, they are published
9 already on a facility level basis on the compare website.
10 They are reported for dialysis adequacy, anemia status, and
11 survival.

12 DR. REISCHAUER: But these aren't risk adjusted?

13 MS. RAY: The dialysis adequacy and anemia, to my
14 knowledge are not. The survival is listed in three
15 categories so it's as expected, more than expected, or less
16 than expected.

17 So that leads us to our draft recommendation, that
18 the Congress should establish a quality incentive payment
19 policy for outpatient dialysis services. The spending
20 implications of the recommendation as it's currently crafted
21 is none. And it would maintain access to high quality care
22 for beneficiaries.

1 MR. HACKBARTH: So we're talking about, you
2 referred earlier, to 1 or 2 percent. So we would set aside
3 1 or 2 percent of the expected payments in the pool for
4 distribution based on the quality indicators?

5 MS. RAY: Right.

6 MR. HACKBARTH: So it's a budget neutral proposal.

7 MS. RAY: Right. I think my mailing actually had
8 1 to 3 percent but it's 1 to 2 percent.

9 MR. HACKBARTH: Just one other clarification. We
10 talk about risk adjustment. Are you saying that there's a
11 risk adjustment method that exists on the shelf that could
12 be applied for this purpose or not?

13 MS. RAY: There is sufficient data out there, I
14 think, to risk adjust the measures, both with the medical
15 evidence form as well as all the other Part A and Part B
16 claims that CMS's contractors -- that would be the USRDS
17 over at the University of Minnesota and the folks over at
18 the University of Michigan -- who are currently doing CMS's
19 broader bundle. They're actually looking at case-mix
20 adjusting the broader bundle payments using case-mix
21 measures, but there is a lot of work being done in this
22 right now.

1 MR. HACKBARTH: I have Dave Durenberger, Jack, Joe
2 and David Smith.

3 MR. DURENBERGER: First, I just want to compliment
4 you on the analysis. I can't get this excited as you can
5 about this, and I'm sure glad you can. It is really, really
6 well done.

7 But it led me, particularly as you got to the key
8 design issues, it led me to observe that the answer to your
9 second bullet, how should providers be rewarded is with more
10 patients. I've got my health savings account add-on.

11 Providers should be rewarded with more patients.

12 And the third bullet would be how should quality
13 be measured and reported?

14 I would just hope that between now and June you
15 might add -- whether it's in the narrative or wherever it is
16 -- some thoughts about the role of the patient, in
17 particular, in judging quality. You well expressed the
18 concern about cherry picking and so forth in the system and
19 it seems to me the degree to which these patients who are
20 going to be patients for a long, long time are well informed
21 about not only the providers and the services they are
22 receiving, but also about their own role. And I'm making

1 some assumptions because I'm not knowledgeable that if
2 nutrition and nutrition management is a critical factor
3 here, then the patient plays a big role. It isn't just the
4 provider's role. The patient plays an important role.

5 And so from our standpoint, thinking about an
6 ideal way to look at the role that the financing plays in
7 quality improvement and enhancement, we ought to focus or
8 ask somebody to focus sometime on the role of the patient in
9 all the respects. If you think that's a good idea, I hope
10 you would look at it.

11 MR. HACKBARTH: I think that's an excellent point.
12 I don't see it as mutually exclusive. I think you can both
13 have a financial reward for providers and use the same
14 information to educate patients and potentially shift
15 patient volume over time, as well. I think they're
16 complementary, not mutually exclusive.

17 Jack Rowe.

18 DR. ROWE: I have a couple of points here. I
19 agree this is very well done.

20 I think you gave some examples, Nancy, of the
21 importance of both physicians and facilities in your
22 comments but I think we could have a little more of that in

1 the text itself. I think it's really key here from my point
2 of view, and I've had the opportunity to talk with the staff
3 a little bit about this, that we all recognize that the
4 physician can be incentivized to improve quality very
5 significantly in a number of ways by paying closer attention
6 to issues such as nutrition and hematocrit and KT/V and
7 vascular access and all of that.

8 But in addition, the facility can. Because if you
9 can imagine that if there was a significant incentive for
10 facilities to enhance nutritional status, and if a facility
11 was big enough, it would be incentive to hire a dietitian to
12 be there. The patients are sitting there on the machine,
13 and give much more advice and counsel and review of dietary
14 habits and diet content and everything else, and do measures
15 of the nutritional status, et cetera. And a variety of
16 those are available beyond albumin. And so I think it's
17 important to emphasize we have to incent both the doctors
18 and the facilities.

19 With respect to that, there are some places in the
20 document where it's ambiguous. For instance, on page 16,
21 that's one case but there are others, where you talk about
22 CMS as planning to incent providers. And you don't make it

1 clear whether they mean doctors or facilities. It sounds
2 like facilities to me.

3 MS. RAY: In the new demonstration it is just
4 facility.

5 DR. ROWE: But I think what I'd like to do is have
6 us adopt an approach here where we don't just talk about
7 providers, like on these slides, but doctors and facilities
8 because I think we have to deal with them separately.

9 With respect of the quality issues, I think 1 to 2
10 or 1 to 3 percent doesn't sound like a lot. But then, when
11 you start to look at these margins, it begins to look pretty
12 significant in terms of the proportion of the margin. So I
13 think it is a meaningful number.

14 MR. HACKBARTH: The other thing on that, my first
15 reaction was that's not very much. But if it's 2 percent
16 and, depending on your distribution formula, only 25 percent
17 qualify there's a lot of leverage there. So you have 2
18 percent of the total payments going to 25 or 30 or 40
19 percent of the providers. They're getting a pretty
20 significant bump.

21 MS. RAY: I'd don't follow your comment about 25
22 to 40 percent of the provider population.

1 DR. ROWE: He's saying only one-quarter of them
2 qualify and if it's cost neutral you take 2 percent of the
3 whole thing and you give it all to that quarter, then
4 they're going to get 6 percent.

5 MS. RAY: I know I mentioned in my mailing
6 materials and I don't know if you're referring to this NCQA
7 threshold of the number of patients to develop a stable --
8 that's not what you're referring to?

9 MR. HACKBARTH: No, it's not. What I'm referring
10 to is the design and I'm jumping way ahead so let me go back
11 a couple of steps.

12 Part of implementing a program such as this is
13 deciding how much money is in the pool and then the second
14 part is what's the distribution formula. A couple comments
15 on that.

16 One is, in keeping with our past discussions, I
17 think what we're talking about is giving the bulk of the
18 incentive payments to providers who have the absolute
19 highest levels of performance on the pertinent measures but
20 reserving a piece of the pool to reward providers who have
21 shown significant improvement in their performance. I think
22 that's the approach that we've talked about.

1 And then the next question is okay, if we're
2 talking about the providers with the absolute highest levels
3 of performance, where is that threshold set? Is it set so
4 it's the top 10 percent of providers, the top 25 percent of
5 providers? That's the issue that I was leaping ahead
6 towards.

7 If you focus the incentive payments on 25 or 30
8 percent of the providers with the absolute best performance,
9 then the leverage becomes pretty significant.

10 DR. ROWE: I agree with that and there are a
11 couple of different ways you could do it. I would also
12 suggest that with respect to the quality measurement, with
13 respect to both the physicians and the facilities, you could
14 consider a floor of acceptable quality that we could migrate
15 northward over time, as well as a level of quality or a
16 change in quality that would trigger a payment. And if you
17 did that the floor would be what you would have to reach in
18 order to be an accredited Medicare nephrologist or facility.
19 And if you didn't meet it, you didn't meet the conditions of
20 participation.

21 Now there are access issues, et cetera, here. But
22 if we're serious about paying for performance what you could

1 say is this is the standard of care that we believe Medicare
2 beneficiaries deserve. We finally have found an area on
3 medicine that we can measure quality, we think, reliably.
4 And if you don't meet this, then you don't get to have
5 Medicare beneficiaries, either as a doctor or a facility.

6 So you can use quality two ways. It's not just
7 moving the money around in a cost-neutral way. It's also,
8 perhaps, influencing volume. Because if there are two
9 facilities in the town -- this gets to David's point -- or
10 two nephrologists in the town, and one isn't meeting the
11 minimum quality standards, then the other nephrologist is
12 getting those cases. He doesn't have to get paid any more
13 per case.

14 Another point on this is risk adjustment. I think
15 that the assumption in your comments was that there are some
16 ways to risk adjust this, that it would be important to risk
17 adjust it, and I agree with that. But the assumption, I
18 think in what I read and heard, is that it would be the
19 entire population.

20 I think one of the problems with this population
21 is that if you've seen one dialysis patient, you've seen one
22 dialysis patient. They're very different. There's a subset

1 who are diabetic, that may be 40 percent. Then there are
2 patients waiting for transplantation. Then there are
3 patients who are dying of some other disease and they're
4 going to gradually do worse and worse, independent of what
5 the quality of the doctor or the facility is. Their
6 measures are going to go down because, in fact, they have a
7 fatal disease. We shouldn't be penalizing the facility or
8 the doctor because somebody with disseminated cancer is
9 losing their functional status. So we have to be careful
10 about it.

11 And I would think that one way to do it is to go
12 with it and say okay, we're not necessarily going to use
13 these measures for incentive payments on the entire patient
14 population. We're going to take a subset, as we start, of
15 the patient population. We'll take all of the diabetics and
16 the polycystic kidney disease patients or whatever, and
17 we'll use those, risk adjust those within those categories.
18 It might be half the population to start, walk before we
19 run, and not wind up penalizing facilities because some of
20 the patients -- because they're willing to take patients
21 who, in fact, are dying or who are very impaired or
22 whatever. Because we don't want people cherry picking and

1 being disadvantaged because they didn't take a patient.

2 It's mentioned here but I'm just thinking of a way
3 of getting around it, particularly for a small facility
4 that's got 15 stations or something, or a nephrologist with
5 a small population of patients.

6 So these are just a couple random thoughts about
7 how you might go ahead with this. I think it's very, very
8 interesting. And I would push you further along on the bone
9 disease access ideas, as well, and see if we can find five,
10 not two, measures. Thank you.

11 DR. NEWHOUSE: I had a couple suggestions, one for
12 research that might change this slide.

13 Table 4 in our briefing materials has some notable
14 gains in quality of care. The percentage receiving
15 inadequate treatment goes down by half over four years, from
16 22 to 11, and percentage with low anemia goes down by more
17 than half from 57 to 24.

18 My suggestion is that you might think about
19 whether you can do any analysis that would look at whether
20 that has had any effect on other Medicare costs for this
21 population. Because if the quality incentives are effective
22 -- and if they're not effective why are we doing it -- and

1 there are effects in other areas, the fact that you're not
2 getting inadequate dialysis means you don't have to be
3 hospitalized at some point. Then the spending implications
4 are actually that this is cost saving.

5 And it would be nice if we could have some
6 documentation of that. I would think, in principle, that
7 analysis could be done.

8 The second point I wanted to make was that there
9 was a Ph.D. dissertation done a few years ago on quality of
10 care in the New York cardiac surgeon system that looked at
11 variability over time. In fact, there's quite a bit of
12 variability, and a lot of the variation is just kind of
13 random noise because of inadequate risk adjustment, which
14 suggests -- the student developed some statistical methods
15 for smoothing this over several years.

16 Which suggests if we go forward with this and
17 probably also beyond the ESRD setting, that if we're going
18 to reward performance, we would do some kind of multi-year
19 average performance, so that you didn't get bounced in or
20 out of your bonus or penalty by some random draw from the
21 patient mix.

22 MR. SMITH: Thanks, Glenn.

1 Joe joins Jack and David in raising some of the
2 questions that are in my mind, so I'll be brief.

3 But it does seem to me that the design issues here
4 are tricky. I have no idea whether or not 1 percent or 2
5 percent is powerful enough, and whether or not across
6 settings whether or not the same percentages would hold. I
7 think we need to think more carefully about that. But it
8 obviously depends a lot on how the 2 percent is distributed.
9 If you distribute it to 80 percent of the providers, it's
10 not as powerful if you distribute it to 40.

11 But that connects with another design issue,
12 which is what you hope with a quality payment incentive is
13 not only the folks who win the prize this year improve, but
14 that everybody improves. That this has got a pull effect on
15 the system as a whole. We need to be careful that we don't
16 concentrate so much on the leverage issue that we neglect
17 the pull issue.

18 Which connects with Jack's question about whether
19 or not there's a facility death penalty. It's an important
20 one, but it has very important access issues and probably
21 access issues not simply quantitatively but distributionally
22 as well. We ought to think about how to link that question.

1 I think Jack's right to raise it, that it becomes a
2 condition of participation to meet a threshold. But maybe
3 in a more subtle way to link it with the issues that Dave
4 raises about can we use this to drive patients to high
5 quality providers, perhaps even thinking about financial
6 incentives to patients, not simply access to high quality
7 information about quality differences.

8 These are tricky questions that are going to come
9 up again and again over the next two days. They're going to
10 be very important in January. I think we ought to step back
11 and ask ourselves is there a systematic way to try to think
12 about this? And most importantly, how do we make sure that
13 even though only Nick gets the reward this year, that my
14 incentive to improve is as powerful?

15 That's how we make the system better, not by
16 figuring out how to distribute 1 or 2 percent around a very
17 small number of already, in most cases, already high quality
18 providers.

19 MR. HACKBARTH: Those are excellent points.

20 I think isn't part of the answer a tool for
21 addressing the latter point is by reserving a piece of the
22 incentive pool for improvement, as opposed to just using it

1 all to reward absolute high levels of high performance?

2 MR. SMITH: I think that's right. Again, the
3 distribution of whatever the incentive pool is among high
4 rates of improvement above whatever the appropriate minimum
5 threshold is, how that compares to how you distribute this
6 to already high quality providers.

7 To some extent, as we think about the broad
8 beneficiary population, we ought not to be interested in
9 spending as much money to reward high quality as we would to
10 reward high levels of improvement.

11 On the other hand, who knows what that induces at
12 the high quality providers if they are somehow -- they can't
13 get an increased piece of the action until their performance
14 declines so that it can turn around and improve. That would
15 be obviously a perverse outcome. So this is trickier, I
16 think, then we're yet up to, but critical stuff.

17 DR. STOWERS: I won't belabor what David said, but
18 I was going to talk about the same thing. I have a little
19 bit of a problem with this high amount of set-aside for the
20 few that reach a real high standard and de-incentivizing the
21 masses of a beneficiaries that we're really trying to get
22 the standard raised, rather than setting some kind of a

1 reasonable standard that a lot more could meet and be
2 incentivized to reach.

3 The other thing, I think, we've talked about for a
4 long time is whether this set-aside ought to come out of
5 existing payments or whether it ought to come out of updates
6 along the way. There's kind of a de-incentivization along
7 the way if we talk about taking out of their existing
8 payments and then try to fight to get that back. I think we
9 maybe want to be clear that when we talk about taking set-
10 aside money that it's not coming out of what they're making
11 now.

12 MR. HACKBARTH: The dollars are fungible.
13 Mathematically I think it works out the same but there may
14 be an important packaging question.

15 DR. STOWERS: But it's a packaging question
16 because you hear on the street, so to speak, that they're
17 going to take it away from me and I have to fight back for
18 it, so I don't want in this quality thing.

19 DR. ROWE: Ray, as I recall, we have like 13 years
20 without an update. So if we promise them that we're going
21 to give it to them in the updates, that might not be too
22 incenting, because they're not going to believe there is an

1 update.

2 DR. STOWERS: I hear you. But instead of an
3 updated we now have this quality money. I'm saying instead
4 of. We now have quality money out there that you could
5 earn.

6 MS. DePARLE: Is there a recommendation that there
7 be an annual update? I know we're making a recommendation
8 for an update this year, but are we recommending to Congress
9 anything about putting that into law?

10 DR. ROWE: It's in the bill, isn't it? The
11 Medicare bill.

12 MS. DePARLE: I don't think so. It's not in the
13 bill. They gave them an update for one year.

14 MS. RAY: Right. The bill gives them 1.6 percent
15 in 2005. We can, of course, discuss if the Commission wants
16 to go down that road about whether or not --

17 MS. DePARLE: I think it's the only provider that
18 doesn't have some provision in law, is that right?

19 MS. RAY: My impression is all the other providers
20 do have that provision in law, yes. I mean hospitals and...

21 MR. HACKBARTH: Implicit in what we do, and we do
22 review the rates each year, is that within our framework

1 they do have an annual update analysis. But you're right
2 that something the industry has sought is a formal
3 legislative recognition of that.

4 MS. DePARLE: That wasn't actually my point. It's
5 just Jack reminded me about the 13 years.

6 I'm excited about the opportunity here to do
7 something to improve quality, but I guess I just want to
8 agree with David that I think it's tricky and so I have some
9 both substantive and practical packaging, I think was the
10 word you used, policy concerns about the way that we go
11 about this and the design of it.

12 Given what we just saw about the trends and the
13 margins in the industry, I don't feel comfortable saying
14 that what we would do on a quality incentive payment policy
15 should be budgeted neutral. I also think the recent history
16 of these ideas, which is very recent since the one I'm aware
17 of is what's in the current Medicare bill, is to make it on
18 top of whatever the provider is getting.

19 In an ideal world what Jack and Joe have talked
20 about, where you would have a condition of participation
21 that everyone has to meet that's much higher than people
22 are meeting now. And then you go on beyond that, that's how

1 we'd all choose to operate. But I just don't think that's
2 realistic.

3 And so I think if we want to move forward here, I
4 would not vote to do this budget neutral at this point.

5 DR. NEWHOUSE: I just wanted to comment quickly on
6 the issue that both David and Ray raised by doing it on an
7 absolute level of quality versus a change in quality or an
8 improvement.

9 The reason I would de-emphasize, though not zero
10 the improvement side, which I think it sounds like you would
11 emphasize, is a portion of what you were alluding to were
12 the high performer degrading their performance to improve.
13 But in general, anybody looking at this would say what's
14 going to happen downstream in future years?

15 Depending on how the payment formula goes for how
16 much payment there is for how much improvement, I may choose
17 to withhold some improvement I could make now to more
18 improvement next year and get my payment next year if I'm
19 looking at something that if I do the best I can this year I
20 get something more this year but then I get nothing more
21 than future.

22 In general, I think there's serious issues with

1 how the improvement thing plays out over time, which is why
2 I would put more of the money on absolute performance,
3 though I don't have really well-formed notions of whether
4 absolute means the top 10 percent or the top 70 percent.

5 MR. SMITH: I think this is exactly the way, Joe,
6 that the question of how do we distribute a quality pot
7 interacts with the question Jack raises about an absolute
8 threshold as a condition of participation. It seems to me
9 that if we could link those two notions, that we've got a
10 part of money somehow divvied up between high performers and
11 improvement, but we've got a threshold which assures us of a
12 minimal level of quality and then are prepared to reward
13 improvement more than absolute performance above that level,
14 my guess -- but it's why I think these are tricky question
15 and not easy ones -- my guess is we'd have a broader impact
16 on a larger beneficiary population, which ought to be one of
17 our objectives.

18 DR. NEWHOUSE: That's correct.

19 DR. ROWE: My concern with your thought, Joe, and
20 it's kind of an interesting question about absolute versus
21 change over time, has to do with the clinical reality.

22 I think that you can have an absolute measure if

1 it's a process measure. Did the patient did Epo? Did the
2 patient get an albumin measured? Did the patient have a
3 dietary consultation? Did the patient do this? Did you do
4 that?

5 But if you have an outcome measure, a clinical
6 outcome measure, what is the functional status of the
7 patient? What's their weight? What's their muscle mass?
8 What's their blah, blah, blah? It takes a long time to
9 build up bones for people who have renal disease-related
10 osteomalacia. It takes a long time to get people to
11 understand the dietary restrictions and to be compliant with
12 the diet and get back in shape, et cetera, et cetera.

13 What you want to do is if somebody is going from a
14 relatively low level and is improving and getting toward
15 your standard but not yet there, you want to certainly
16 reward them.

17 So I think if we had process measures, I'm with
18 you. If we have clinical outcome measures, I'd like to see
19 some consideration for improvement. We can go around and
20 around on this, but I would like to make that distinction.

21 MR. HACKBARTH: The other thought that raises in
22 my mind, if you're talking about outcome measures and

1 there's imprecision, as there inevitably is, in your risk
2 adjustment, having an improvement payment is perhaps a bit
3 of a hedge against imprecision in your risk adjustment.

4 If you've got a facility that's consistently
5 attracting caring for patients that are more complicated and
6 higher risk, beyond which you fully account for in your risk
7 adjustment, they may look poor on your absolute values, but
8 if they are improving compared to themselves over time then
9 they would be rewarded.

10 DR. NEWHOUSE: The improvement may just be because
11 the risk adjustment was incomplete so I got better patients
12 next year. You may be just rewarding noise in the
13 improvement.

14 MR. HACKBARTH: Yes, and that's an issues with
15 risk adjustment across the board in linking payment.

16 DR. NEWHOUSE: It's more of an issue in change
17 than in levels.

18 MR. HACKBARTH: Lots of things to discuss.

19 Thank you, Nancy. We need to move on now to M+C.
20 Very thought provoking.

21 MR. DURENBERGER: Scott, before you begin, would
22 you just clarify for me, when you use the phrases in the

1 beginning, private plans and delivery systems provide -- I'm
2 just unclear exactly how that reads. Just so I don't have
3 to ask it later on. You talk about doctors, hospitals,
4 blah, blah, blah, all that sort of thing.

5 DR. HARRISON: You mean what the delivery system
6 is?

7 MR. DURENBERGER: What are we talking about when
8 we say --

9 MR. HACKBARTH: Where are you looking Dave, so we
10 can all get on the same page?

11 MR. DURENBERGER: In just the basic language. He
12 uses the language private plans provide delivery systems and
13 I just need to understand what it is. It's probably so
14 obvious...

15 DR. HARRISON: That would include networks, care
16 coordination, whatever techniques they're using to have care
17 delivered that might be different than the fee-for-service.

18 MedPAC has a long history of supporting private
19 plans in the Medicare program. The Commission strongly
20 believes that beneficiaries should be given the choice of
21 delivery systems that private plans can provide. Private
22 plan, through financial incentives, care coordination, and

1 other management techniques, have the potential to improve
2 the efficiency and quality of health care services delivered
3 to Medicare beneficiaries.

4 The current incarnation of privatize plans is the
5 Medicare+Choice program. The Medicare+Choice program has
6 provided the majority of Medicare beneficiaries a choice of
7 delivery systems and MedPAC has supported that choice and
8 pushed for the choice to be financially neutral to the
9 Medicare fee-for-service program.

10 Congress has just passed legislation establishing
11 a new Medicare Advantage program, however much of that
12 program will be based on M+C plans. M+C plans will become
13 known as Medicare Advantage and many of the same issues we
14 have been addressing will continue to need addressing.

15 The reform bill has given MedPAC several mandated
16 studies involving broad issues surrounding Medicare
17 Advantage plans, including a study due in 18 months that
18 will give us the opportunity to examine financial neutrality
19 and payment area issues.

20 For the short run, including our work today, we
21 are focusing on issues that are important for the current
22 program as it transitions to the new program. And these

1 issues, however, will also be important for the long run.

2 Dan and I will present three draft recommendations
3 today. The first two arise from the new risk adjustment
4 system that will be implemented in January. MedPAC has
5 stated many times that risk adjustment is crucial if we are
6 to pay private risk bearing plans properly. This would
7 include not only M+C plans but also drug plans and Medicare
8 Advantage plans.

9 Risk adjustment can be used to help create
10 financially neutral choices. CMS has made a choice in
11 implementing the new risk adjustment system that has the
12 effect of moving away from financial neutrality. And the
13 first draft recommendation would have CMS reverse its
14 decision.

15 The new risk adjustment system also presents an
16 opportunity to expand plan choice to ESRD beneficiaries.
17 And the second draft recommendation would take advantage of
18 that opportunity.

19 The final draft recommendation reflects an
20 extension of the Commission's analysis of using payment
21 incentives to improve the quality of plan services. I will
22 present that draft recommendation after Dan has finished

1 presenting the first two.

2 DR. ZABINSKI: An important change facing plans in
3 2004 is that CMS will begin using a new system for risk
4 adjusting their payments. A little bit of background on
5 this thing is that the Agency has named the new risk
6 adjuster the CMS-HCC. And this model measures an enrollee's
7 risk, that is their expected costliness, using the
8 demographics and conditions diagnosed during inpatient,
9 outpatient, and physician encounters in the previous year.
10 This model should be an improvement over the current risk
11 adjuster, which uses only diagnosis from inpatient stays to
12 evaluate enrollee's risks.

13 Probably the most important attribute of this new
14 risk adjuster is it has the potential to substantially
15 affect payments.

16 Today I'm going to focus on two key developments
17 regarding the new risk adjustment system. The first key
18 development is that in 2004 CMS will make proportional
19 increases to all payments adjusted by the CMS-HCC. The
20 purpose is to offset reduced payments that would otherwise
21 occur under the CMS-HCC to make them budget neutral with a
22 demographic adjuster that CMS currently uses in setting M+C

1 payments.

2 Some argue that this policy is necessary to help
3 stabilize Medicare+Choice and prevent plan withdrawals.

4 A second key development regarding the new risk
5 adjustment system is that CMS has created a version of the
6 CMS-HCC designed specifically to adjust payments for ESRD
7 beneficiaries. These beneficiaries are currently barred
8 from enrolling in Medicare+Choice, in part because the
9 method currently used to risk adjust payments performed
10 quite poorly. But the new risk adjuster should do much
11 better.

12 Over our next four slides, we present issues
13 related to these two developments I just discussed and two
14 related draft recommendations. First, I'll discuss concerns
15 over CMS's decision to proportionally increase risk adjusted
16 payments in 2004. Previously, the Commission has
17 recommended that M+C payments should be risk adjusted and
18 that payments should be financially neutral between the
19 Medicare+Choice and traditional Medicare sectors.

20 And just to refresh your memory, financial
21 neutrality means that on average payments should be equal in
22 Medicare+Choice and traditional Medicare after accounting

1 for differences in risk.

2 It's the job of risk adjustment to account for
3 those differences in risk and put the M+C and fee-for-
4 service sectors on a level playing field in terms of risk
5 differences. But CMS's decision to proportionally increase
6 risk adjustment payments in 2004 will have the adverse
7 effect of moving us away from the concept of a level playing
8 field and financial neutrality.

9 Another concern over CMS's decision to
10 proportionally increase risk adjusted payments is that CMS
11 may have overestimated how much the CMS-HCC will actually
12 reduce payments. This is because the data that CMS used to
13 estimate the impact of the CMS-HCC on payments came from a
14 time when payments depended little on how providers in
15 Medicare+Choice code enrollee's conditions. Consequently,
16 providers may have under-reported conditions, making
17 enrollees look healthier than they actually are. But
18 providers will likely be more diligent when coding
19 conditions --

20 MS. ROSENBLATT: Dan can I ask a clarifying
21 question on that? That third billet, CMS may have
22 overestimated, if I were to ask somebody at CMS why they did

1 that, would this be their answer or are you guessing that
2 this is their answer?

3 DR. HARRISON: Are you asking why they
4 overestimated?

5 MS. ROSENBLATT: Why they're making the
6 adjustment, the 4.9 percent? If I were to go to somebody at
7 CMS and say why are you making the 4.9 percent adjustment,
8 what would their answer be?

9 DR. ZABINSKI: I would say that it's to help
10 stabilize the program. That's in their notice last March
11 and they had the 45-day notice and then the final notice
12 last spring. And that was in the notice, that the purpose
13 was to stabilize the program.

14 MR. HACKBARTH: That's what I've heard personally
15 from people in the administration as to why they think this
16 is important.

17 DR. ROWE: [off microphone.] Because of this
18 reason that the doctors or the hospitals in Medicare+Choice
19 --

20 DR. REISCHAUER: No, it's that if they took the
21 4.9 percent out of the system plans would drop out.

22 DR. ROWE: Can I ask you, just to clarify, what

1 exactly -- on page five you say they want to put 4.9 percent
2 in to make it budget neutral. Right? You said in 2004 CMS
3 will increase the risk adjusted payments by -- and then the
4 actual number is 4.9 percent -- to make them budget neutral
5 with the demographic adjuster, right? That's what it says.

6 Now this one says increasing the risk adjusted
7 payment moves us away from financial neutrality because you
8 think it's too much. You think it's too much or you think
9 that adjustment shouldn't be made at all because the
10 adjustment theoretically moves us away -- I'm trying to
11 figure out whether we're against any adjustment because it's
12 inconsistent with the principle, or you think the numbers
13 too big?

14 MR. HACKBARTH: They're two different benchmarks.
15 One, when the administration, when CMS refers to budget
16 neutrality, they're comparing the payments under the new
17 system to what would have been spent under the old
18 demographic system. So it's budget neutral relative to
19 that. Plans get paid the same amount as they would have
20 before --

21 DR. ROWE: [off microphone.] That's budget
22 neutral longitudinally.

1 MR. HACKBARTH: The other reference point is are
2 we paying the same amount that traditional fee-for-service
3 Medicare would have paid for the same patients? That's the
4 financial neutrality that MedPAC has focused on in the past.
5 So there are two different benchmarks.

6 So a system that is budget neutral relative to the
7 demographic adjustment is not neutral relative to what fee-
8 for-service Medicare would have paid. What we are finding
9 is based on these new risk adjustment measures that the
10 enrolled population in private plans is healthier than in
11 fee-for-service Medicare and their payment should be falling
12 as a result of improved risk adjustment.

13 MS. ROSENBLATT: Can I ask one more clarifying
14 question? Was there any reason why -- we went from
15 demographic to PIP -- whatever it was called -- to the new
16 thing. Why do they go budget neutral to demographic instead
17 of the PIP one?

18 DR. ZABINSKI: I don't know.

19 DR. HARRISON: Actually, in '03, this year, they
20 actually went budget neutral to demographic using the PIP-
21 DCG. So there's a little bit of money this year that was
22 given back, like .6 percent, something like that, to get

1 from the current 90/10 blend of PIP-DCG back down to the
2 demographic. So they've done it two years, '03 and '04.

3 DR. MILLER: Just the conceptual response to the
4 question is that they were trying to maintain the dollars
5 that the plans were currently getting? Is that a fair
6 response? Under the old risk adjustment system. the new
7 risk adjustment system would have pulled their --

8 MS. ROSENBLATT: That's what I'm asking. It
9 sounds like it didn't go to the 90/10, it went back to
10 demographic. Or am I not understanding it?

11 DR. HARRISON: That's right, it's going back to
12 the demographic, which I guess we sort of consider to be the
13 old system.

14 MS. ROSENBLATT: It's as though anything beyond
15 demographic never happened.

16 DR. HARRISON: Yes.

17 DR. MILLER: This is more of a sidebar. The other
18 reason that people will give for this is that there are
19 differences of opinion about how the legislation is
20 interpreted. When the law was written, there are some who
21 argue that this was the intent of the law and some who argue
22 that this was not the intent of the law. So you have that

1 overlay just to make it a little more confusing.

2 MR. HACKBARTH: Of course, what we want to do is
3 bypass what is the correct legal interpretation of the
4 existing law and not get involved in that at all but simply
5 discuss what we think the appropriate policy should be for
6 the program.

7 DR. ROWE: [off microphone.] I guess at this
8 point we're at the point where we're looking at the
9 recommendation, so I'll hold my question until then. But I
10 want to ask it before we get to dialysis.

11 MR. HACKBARTH: So why don't you proceed.

12 DR. ZABINSKI: Now because of these issues
13 regarding CMS's policy to proportionally increase the risk
14 adjusted payments, we have developed this draft
15 recommendation, that CMS should not continue to adjust
16 payments under the CMS-HCC to make them budget neutral with
17 the current demographic adjuster. This demographic would
18 have no impact on program spending nor would it have an
19 effect on beneficiaries or providers. And this is because
20 there has not been action to increase risk adjusted payments
21 in any way in 2005, which is the time when this
22 recommendation would first apply.

1 DR. ROWE: What's not clear to me, and maybe -- I
2 was at risk for understanding it a minute ago in the
3 conversation but I think I need more help.

4 Let's get to the neutrality question of M+C versus
5 traditional, which is the second version of neutrality.

6 MR. HACKBARTH: [off microphone.] Right, and the
7 one that we focus on.

8 DR. ROWE: Congress or somebody raised the
9 payments in the so-called floor counties, right? That was
10 sort of done. And that was done for whatever policy reason,
11 access, choice, whatever it was.

12 When we're now comparing the payments in M+C
13 versus traditional for the relative morbidity or risk
14 associated with the population, are we taking out that extra
15 payment that was added to the floor counties, so we're
16 comparing apples to apples? Or are we including those extra
17 dollars that were put in those floor counties because that
18 was a separate policy issue that was done for a separate
19 reason? So it seems to me we should take that out and then
20 see how much are the M+C plans getting paid for the same
21 patient? Is that clear?

22 MR. HACKBARTH: Yes, it is clear.

1 Just to clarify that record, we opposed the floor
2 payments, as well, because they violated the neutrality
3 principle and we thought they would be ineffectual at any
4 rate. Now there's a second question of neutrality.

5 DR. ROWE: [off microphone.] But isn't that
6 influencing our calculation?

7 MR. HACKBARTH: The staff have consistently given
8 us two numbers. One which is the overpayment that results
9 from the floors and that stuff, and then a second that is
10 the additional overpayment attributable to the approach to
11 phasing in risk adjustment, the budget neutrality provision
12 of risk adjustment. So why don't you tell us again what
13 those two distinct numbers are?

14 DR. ZABINSKI: The overpayment from the floors, et
15 cetera, as Scott has estimated, is that the average payment
16 rate is about 3 percent higher than what the average fee-
17 for-service beneficiary costs.

18 DR. ROWE: If you take that out, then what is it?

19 DR. ZABINSKI: Then it's zero. Well, it would
20 reduce the base payment rates by 3 percent, on average, if
21 you take that out. Basically, if you set all base payment
22 rates equal to focal fee-for-service spending, then the

1 average base payment rate would go down by 3 percent.

2 DR. ROWE: So what you're saying then is we're
3 currently paying plans 103 percent, but if we correct for
4 whatever the reason was, floor payment thing, we're actually
5 paying out 100 percent of fee-for-service?

6 DR. ZABINSKI: Right.

7 DR. ROWE: Because that's an important --

8 DR. HARRISON: That's for a demographically
9 similar population.

10 MR. HACKBARTH: That's assuming there aren't any
11 selection issues. The increment that would be attributable
12 to using the current budget neutrality approach, if it's
13 done through the full phase-in, is an additional increment
14 of 16 percent.

15 DR. HARRISON: Let me talk about that number for
16 just a second. The way that number was arrived at, CMS did
17 a simulation. They said okay, we're going to pay you under
18 the demographic system. You get X dollars. We're going to
19 take your same patients that we have the data for. We're
20 going to run them through the new system and find out what
21 we're going to pay you. And it turns out you'd get 16.3
22 percent less. That's where that number came from. That

1 includes the floors, right. That includes what would happen
2 changing this one risk adjuster. So that's where that
3 number comes from.

4 It may not always be appropriate to add or
5 multiply that with the other differences because we do have
6 some mathematical issues, but that's generally where we are.

7 MS. THOMAS: I think it's also important to point
8 out that that number could change based on what plans
9 actually enroll and how thoroughly they code diagnoses. So
10 it's an order of magnitude number, -- not an absolute number
11 that we should be focusing on.

12 MS. ROSENBLATT: If I could just, I have a lot of
13 problems with that number because I don't understand what
14 you mean by simulation. It's a much different number. You
15 know, I think we've all been thinking that the selection
16 impact, ever since the Rand study was done, was sort of the
17 range of 5 to 7 percent. And now all of a sudden we're
18 looking at a number like 16 percent.

19 Whenever something like that jumps in my world,
20 there's usually a data problem.

21 So I am very concerned, when I read the stuff for
22 this meeting, I was really concerned about how often we used

1 that 60 percent. Because I'm worried that it's not even an
2 appropriate order of magnitude, given that we've all been
3 thinking about 5 to 7 percent for years now.

4 DR. HARRISON: We think that's right. We think
5 the number will probably will come down. But one of the
6 dangers of the policy is that that number is locked in as an
7 add-on.

8 MR. SMITH: The 4.9.

9 DR. HARRISON: Right.

10 DR. MILLER: Just to be clear, first of all we
11 agree with you and we're trying to not repeat that number as
12 much. And you're right about the materials, and we have had
13 a lot of discussions ongoing while we're doing this work.
14 Your point is well taken. That's a CMS number. We think
15 that CMS may estimate it.

16 However, if the policy were to be rolled forward,
17 even if your mix of patients change, there still would have
18 been an estimated 16 percent add-on to the payment because
19 that percentage was basically built in.

20 The other point I would make is 6 percent, 16
21 percent, forget the number. It's the principle that I think
22 we're really trying to focus on here.

1 DR. ROWE: Let me see if I can --

2 MS. RAPHAEL: I just want to see if I understand
3 the recommendation, because I'm not sure that I do. And I'm
4 going to restate it and tell me if I have this right.

5 We're saying CMS should adjust payments under this
6 new system, the CMS-HCC system. That's the first thing.
7 We're in favor of that. What we're not in favor of is
8 adjusting payments under that system to make them budget
9 neutral with the current system, which is based on
10 demographic adjuster. Is that it?

11 DR. ZABINSKI: That's it.

12 DR. ROWE: Just to get the language straight, on
13 page three, let me just read the first statement we have,
14 because maybe not everybody is quite as into this is you
15 guys, and then we'll read this statement. Page three.

16 Three draft recommendations. Number one, risk
17 adjustment should support principle of financial neutrality.
18 That's what it says. Recommendation: CMS should not
19 continue to adjust payments -- dah, dah, dah -- to make
20 them budget neutral with the current demographic adjuster.

21 I would suggest that unless you're really a
22 cognoscenti, it does appear that those two statements are

1 conflicting.

2 DR. MILLER: We will work on the words. That's
3 fair.

4 MR. HACKBARTH: [off microphone.] This is
5 helpful. The wording is delicate and we need to do a better
6 job.

7 DR. ROWE: So what you're saying is you're in
8 favor of budget neutrality, but not this budget neutrality.

9 DR. ZABINSKI: No, we're in favor of financial
10 neutrality but not budget neutrality.

11 DR. ROWE: Are we talking about amortization or
12 capital expense? What do you mean financial but not budget?

13 MR. HACKBARTH: Maybe a way to express it, maybe,
14 is that what we're opposed to is holding plans harmless
15 against the effect of the new risk adjustment. We think the
16 new risk adjustment is as a good thing to do and we ought to
17 pay according to its results as according to base payments
18 based on the old demographic system.

19 DR. NEWHOUSE: [off microphone.] Maybe we should
20 say what we should do.

21 DR. REISCHAUER: But we're only holding plans in
22 the aggregate harmless when what we want to do is if the

1 application of risk adjustment leads to an aggregate
2 savings, that should rebound to the benefit of the program
3 and not to the Medicare Advantage subset.

4 DR. ROWE: So are we talking about having the same
5 amount of money for the plans and redistributing them around
6 the plans by virtue of some measure of the risk? Or are we
7 talking about reducing the amount of money we would prefer,
8 reduce the amount of money in the plans to make it more
9 relevant to what's going on on the other side?

10 DR. NEWHOUSE: We're in favor of two.

11 DR. REISCHAUER: Number one is the policy.

12 DR. ROWE: And number one is the policy, right.
13 So we should change this language to say that?

14 DR. MILLER: We will redraft it.

15 DR. ROWE: And tell me about the difference
16 between revenue and budget?

17 DR. ZABINSKI: We've made this financial
18 neutrality recommendation a few years ago. Basically you
19 want to pay the same for a beneficiary whether they're in
20 fee-for-service or Medicare+Choice. In order to do that you
21 need to risk adjust them properly. That's financial
22 neutrality.

1 What the budget neutrality adjustment does is you
2 initially risk adjust it and then you add an additional
3 payment on top of it to make it budget neutral. So you're
4 no longer going to be paying an equal amount in fee-for-
5 service as in Medicare+Choice. You're going to be paying
6 more in Medicare+Choice for that person.

7 DR. ROWE: [off microphone.] So you're mitigating
8 the effect of the risk adjustment in this case because it
9 turns out they're less risky. If the people in M+C were
10 more risky, then they'd be getting more.

11 MR. SMITH: [off microphone.] Think of it as
12 payment neutrality rather than budget neutrality.

13 DR. ROWE: [off microphone.] Right, but I think
14 not everybody is going to understand the difference.

15 DR. ZABINSKI: I think this budget neutrality term
16 has been unfortunate, but that's been the one that's been
17 sort of used by the CMS.

18 MR. SMITH: Let me come back to Alice's question
19 for a minute.

20 If the 16.3 is wrong, and we say in the text that
21 it is wrong. We don't know what the right number is, but we
22 know that it's wrong. But the 4.9 is law. So the closer

1 the 16.3, Alice, gets to five or six or seven, the more
2 distorting the 4.9 will be.

3 Of right number is say 7.3 percent instead of 16.3
4 percent. we are going to compensate the plans at a level
5 that assumes that the 16.3 percent is the right number to
6 reflect the healthier population in the plans. So the
7 closer the number comes to your expectation, the more
8 distorting the 4.9 percent gets.

9 MR. HACKBARTH: That's part of the problem, is
10 locking into this number as the right number for the phase-
11 in.

12 MS. ROSENBLATT: My concern is that somebody is
13 going to read the way this is written now -- and I'm glad to
14 hear it's going to change -- and say oh my god, plans are
15 being overpaid by the 16 plus the three. There will be an
16 assumption that plans are being overpaid by 19 percent. And
17 I just look at reality that says a lot of plans have been
18 withdrawing. If they were being overpaid by 19 percent,
19 trust me, nobody would have withdrawn.

20 MR. HACKBARTH: That raises another issue that is
21 still another source of confusion. Again, our consistent
22 benchmark about appropriate payment is what would have been

1 spent for the same patients under traditional fee-for-
2 service. That is our guiding star in all of our
3 recommendations in this area since I've been on the
4 Commission.

5 That does not meet that the payments are adequate
6 to cover the plans' costs or the plans are reaping large
7 profits. That's a completely different issue that has to do
8 with the cost structure of plans. In fact, having been in
9 this world and worked for a plan trying to do this, I know
10 what a disadvantage it is to have higher administrative
11 costs, the marketing costs, and in the case of for-profit
12 plans taxes and the like. So you're behind before you even
13 start in this game.

14 So the plans' cost structure is a completely
15 separate discussion that we've not taken up. We're talking
16 talk about how payments compare to fee-for-service Medicare.

17 MS. ROSENBLATT: I agree with that and that was
18 going to be the second part of my comment, Glenn, because
19 there's an example in the paper that uses \$100 and \$84. And
20 I think that example clouds that issue that you just brought
21 up. I think it really makes it look like the \$100 is an
22 adequate number and it's not.

1 MR. HACKBARTH: I think that's a good suggestion.
2 In fact, it's something that Jack and I talked about on the
3 phone. As we write this material, we need to draw out this
4 distinction and address the issue of paying costs, not
5 empirically try to measure it but just say that's a
6 conceptually different issue and plans may have higher costs
7 in some respects.

8 DR. ROWE: I had three things that I wanted to try
9 to put into the conversation or the discussion part of the
10 paper anyway, that I think address this and give people a
11 fuller feeling for it. One of them is these inherent costs
12 associated -- it's just a different design. That's fine.
13 This is a voluntary program. Plans don't want to
14 participant, they don't have to, as we've seen.

15 Secondly, is the assumption that the benefit
16 package is the same. It's kind of an assumption, you're
17 either getting this benefit in M+C versus you're getting it
18 in traditional. And the fact is that there are benefits in
19 M+C that are not in traditional, preventive benefits, other
20 kinds of disease management programs, et cetera. So we
21 should at least recognize that.

22 The third is the payment from the point of view of

1 the beneficiary because we're always comparing M+C to
2 traditional but, in fact, in the real world it's M+C versus
3 traditional plus Medigap because the beneficiary is paying
4 the Medigap premium. Now a lot of those Medigap programs
5 may disappear overnight with the pharmacy benefit, the
6 expensive ones with the pharmacy benefit are probably not
7 going to be --

8 DR. NEWHOUSE: [off microphone.] Only 8 percent
9 of them have a drug benefit.

10 DR. ROWE: So I think that if you add those three
11 things in the benefit may not be exactly the same because
12 it's saying it's the same cost for the Medicare program kind
13 of assumes that you're buying the same product at the same
14 cost in these two pathways. And the plans would say well,
15 we're not really giving the same product. We're giving a
16 different product.

17 So if we throw that in, I think it enriches
18 wherever we come out in the recommendation. It at least
19 gives it a more fulsome discussion than that example, which
20 I think doesn't do that.

21 DR. REISCHAUER: But the payment that the
22 government is making is for a similar package of benefits.

1 It's true that Medicare+Choice plans have a fuller package
2 of benefits, and that's fine and that's good, but with
3 respect to the calculations that Scott's doing, it's not
4 relevant.

5 MR. SMITH: Scot, let me just check my arithmetic
6 for a moment.

7 Given the MedPAC financial neutrality principle
8 and the implications of the new legislation, is it right to
9 say that in a floor county payments subsequent to the
10 implementation of the legislation would be 7.9 percent
11 higher than the financial neutrality principle would
12 dictate? Can you add the three and the 4.9 together?

13 DR. HARRISON: Not exactly.

14 MR. HACKBARTH: Arithmetic in public is like
15 making sausage in public, it's not a good thing.

16 DR. HARRISON: We've tried to do that because
17 people keeping asking us to do that and I think we should
18 stop because you really need to rebase things. These things
19 are all based off of relative weights and everything. And
20 when you throw different mixes of people from different
21 counties in, things get very messy. The actuaries have to
22 look at this stuff and when they redo things they need to

1 think about the stuff, but it's not as simple as just adding
2 them.

3 MR. HACKBARTH: We need to quickly get to a
4 conclusion here. Have we fully discussed recommendation
5 one? I think so. Let's move on to recommendation two.

6 DR. ZABINSKI: Next I'd like to return to an issue
7 I mentioned earlier, that ESRD beneficiaries currently are
8 barred from enrolling in Medicare+Choice. The staff have
9 identified three factors that support the notion of changing
10 that policy and allowing ESRD beneficiaries full opportunity
11 to enroll in private plans.

12 First, the new risk adjuster will pay plans more
13 accurately for ESRD beneficiaries. Second, results from a
14 demonstration program indicate that ESRD beneficiaries
15 receive equal or better treatment in managed care. And
16 finally, equity in Medicare+Choice requires that all
17 beneficiaries should have full access to managed care
18 settings.

19 That leads to this recommendation, that the
20 Congress should allow beneficiaries with end-stage renal
21 disease to enroll in private plans. This draft
22 recommendation would have no spending impacts, but it might

1 have a positive impact on ESRD beneficiaries who may get
2 better coordinated care in managed care settings. Also,
3 there would be do impact on providers except that dialysis
4 providers would have to negotiate rates with private plans,
5 rather than simply accepting Medicare payment rates.

6 MR. HACKBARTH: Comments or questions?

7 DR. NEWHOUSE: I'm in favor of this recommendation
8 but I'm wondering if a skeptic might say if we observed the
9 same selection we did in M+C, wouldn't this raise what the
10 government was paying downstream if rates got based on fee-
11 for-service? I'm going to the spending implications again.

12 DR. HARRISON: But this risk adjuster that we're
13 using a specifically designed for ESRD beneficiaries with
14 dialysis. They actually put them in a separate pool and
15 estimated the model.

16 DR. NEWHOUSE: As I say, I'm fine with the
17 recommendation but I think you have to then bring out that
18 you're banking on risk adjustment to keep the spending
19 implications at none. on.

20 DR. ZABINSKI: I want to fully understood
21 understand what you're saying. Are you saying that even if
22 we have this full risk adjuster, it might not do a perfect

1 job?

2 MR. HACKBARTH: Within this class of patients
3 there might be selection?

4 DR. NEWHOUSE: I'm not sure anybody else thinks
5 HCC is the perfect risk adjuster and I would guess that you
6 don't think the ESRD adjuster is the perfect risk adjuster.

7 MR. HACKBARTH: So within this class of patients
8 with ESRD, there may be selection with the healthier ones --

9 DR. NEWHOUSE: It's awfully strong to say there
10 won't be.

11 MR. HACKBARTH: But I'm just trying to understand
12 your point. And to the extent that there's selection within
13 this category, there could be an increase --

14 DR. NEWHOUSE: We've got the composite rate where
15 it is, but then what this would do, when we look at those
16 payment-to-cost ratios that we looked at in the earlier
17 section downstream, they would be headed down if there is
18 selection against the traditional program and there would be
19 pressure to raise that rate. That's the only point I'm...

20 DR. HARRISON: Joe, are you suggesting that we
21 want to add something about it needs to be rebased now and
22 then? Would that help?

1 DR. NEWHOUSE: I haven't thought that far ahead
2 but maybe I would just add at this point that it's important
3 that risk adjustment be implemented as part of this.

4 MR. HACKBARTH: Yes, acknowledge that in the
5 accompanying text.

6 DR. REISCHAUER: Under undercurrent law, ESRD
7 patients aren't allowed to sign up once they've been
8 diagnosed. My understanding is if they develop symptoms
9 while they're enrolled in a Medicare+Choice plans they can
10 stay in a Medicare+Choice plans.

11 DR. ZABINSKI: Right.

12 DR. REISCHAUER: Which means that suddenly we'll
13 be paying them, under this system, more. So by definition -
14 - no?

15 DR. HARRISON: They're currently paid a state-wide
16 average for ESRD beneficiaries.

17 DR. REISCHAUER: So we already adjust it?

18 DR. HARRISON: We already do pay for ESRD
19 beneficiaries in plans but it's a state-wide rate, one
20 state-wide rate.

21 DR. ZABINSKI: And it's not risk adjusted in any
22 way.

1 DR. REISCHAUER: It's not a lot of people, I know
2 that. And probably many of them switch out, if they were
3 rolled. But I think we should mention in the chapter anyway
4 what the current situation is.

5 The second thing is, not to tie this with the
6 previous discussion we had, but we also, if we're going to
7 go into a long discussion of paying for quality for dialysis
8 patients, we might suggest that this would also apply to
9 these plans.

10 DR. NEWHOUSE: That's our recommendation three.

11 MR. HACKBARTH: No, he's talking about plans that
12 provide or take responsibly for dialysis care.

13 DR. NEWHOUSE: [off microphone.] That's sort of a
14 subset.

15 DR. REISCHAUER: Right.

16 DR. ROWE: [off microphone.] As long as the
17 things that you're evaluating them on are things under their
18 control.

19 DR. REISCHAUER: Same deal as the fee-for-service.

20 DR. NELSON: Do I understand right then, the end-
21 stage renal disease patients enrolled in private plans would
22 take with them the composite rate, the same reimbursement

1 formula as they currently take to a dialysis unit? No?

2 DR. ZABINSKI: No.

3 DR. NELSON: I understand the risk adjustment.

4 What accommodates the additional facility costs and all that
5 kind of stuff that goes with an end-stage patient?

6 MR. HACKBARTH: It's a capitated rate.

7 DR. NELSON: And would be set by risk adjustment
8 to take care of the facilities --

9 MR. HACKBARTH: It reflects the underlying
10 Medicare payment structure and says Medicare costs like this
11 for these patients with this category. And so there's an
12 added -- as we've measured it -- an added increment of costs
13 associated with this payment category. So then you take the
14 base private plan rates, whatever they are, whatever they
15 were calculated, and say you get a bump up of this amount
16 for dialysis patients.

17 DR. NELSON: Thank you.

18 MR. HACKBARTH: Next recommendation?

19 DR. HARRISON: In our June report, the Commission
20 supported tying financial incentives to quality for
21 providers and plans. In that report we developed criteria
22 for successful implementation of a financial incentive

1 program. As we noted back in that June chapter,
2 Medicare+Choice plans meet those criteria and this is really
3 what Nancy had up.

4 Evidence-based measures are available. M+C plans
5 already collect data that can be used to assess quality and
6 not cause any added burden to the plans. Plans annually
7 collect audited HEDIS data on process measures such as
8 whether patients receive certain preventive screenings and
9 some outcome measures, such as hemoglobin levels for
10 diabetics and cholesterol control after an acute
11 cardiovascular event.

12 In addition, plans participate annually in the
13 Consumer Assessment of Health Plans Survey, known as CAHPS.
14 The CAHPS data reflect health plan members assessments of
15 the care they receive, their personal doctor and
16 specialists, the plan's customer service, and whether they
17 get the care they need in a timely fashion. While HEDIS and
18 CAHPS scores have been improving, there are still plenty of
19 room in the measures for further improvement.

20 You just really went over all this in the ESRD
21 talk.

22 MR. HACKBARTH: As opposed to going over the same

1 terrain, are there unique issues? Different issues raised
2 by payments for quality in the area of private plans that we
3 didn't touch on in our ESRD discussion?

4 DR. NEWHOUSE: I wonder what we mean in the
5 context of PPO plan, where the traditional issue has been we
6 can't control things. I just raise it as a question.

7 DR. HARRISON: I believe the PPOs plans report
8 most of the same HEDIS and CAHPS data. There may be a
9 couple of exceptions in the HEDIS data.

10 DR. NEWHOUSE: So what the PPO plan, what we would
11 want them to do would be to contract, limit their network in
12 some fashion to providers that performed well on the HEDIS
13 measures? Isn't that their only real instrument?

14 DR. HARRISON: Think it is as financial incentives
15 or other ways of managing care.

16 MR. HACKBARTH: Currently aren't PPOs treated
17 differently, in terms of expectations for quality
18 improvement than the coordinated care plans?

19 DR. HARRISON: I believe they are different for
20 quality improvement.

21 MR. HACKBARTH: I'm pretty sure that's true.

22 MS. MILGATE: The difference, as Scott said, is

1 actually fairly minor, in terms of the HEDIS reporting.
2 They have some exceptions for data that would need to come
3 from medical records, for example, but there are a lot of
4 HEDIS measures that are administrative data that they do
5 report on. So there's some minor exceptions in reporting.
6 And then the current M+C requirements also don't require
7 them to show sustained quality improvement on the national
8 project, which is something that the other plans have to
9 show, the coordinated plans.

10 DR. NEWHOUSE: That's what I was thinking of but I
11 thought that was because the PPO plans argued they didn't
12 have the same degree of control.

13 MS. MILGATE: It was actually -- yes, that was a
14 piece of it for the quality improvement exemption. But CMS
15 still felt like it was possible for them to improve on some
16 of the measures in HEDIS and it has caused some improvement
17 in the HEDIS measures that the PPOs report on. And there
18 are other ways that PPOs can do it other than limiting
19 networks, that some of them have used. Like directly to the
20 consumer to get a mammography, for example, or some other
21 method. But it is a reasonable point that there are some
22 differences between HMOs and PPOs.

1 MS. ROSENBLATT: Two things. One, to add to what
2 Joe said, is private fee-for-service within this
3 recommendation?

4 DR. HARRISON: Private fee-for-service, I believe,
5 is still exempt from reporting and they're exempt from a few
6 other things, too.

7 MS. ROSENBLATT: Say you're exempting it from
8 here?

9 DR. HARRISON: I guess, at this point we would
10 have to, unless the law changes. I guess that's something
11 for discussion. What would we want to do?

12 MR. HACKBARTH: I don't think we can hide behind
13 what the law says. We're about recommending what the law
14 should be. This different type of plan issue is just
15 maddeningly complex. It's almost metaphysical, because we
16 have these legalistic definitions of what organizations are,
17 but in fact it's a real continuum and there are not clear
18 lines distinguishing one from the other.

19 The conceptual distinction that exists in my mind,
20 but it's not embodied in law, is some types of plans
21 basically reflect a choice by the beneficiary to say I don't
22 want somebody else making decisions for me about which

1 provider I go to. I don't want somebody interfering in my
2 physician/patient relationship. I'm a choice advocate.

3 And if that's the sort of arrangement we're
4 talking about, as in the case of private fee-for-service,
5 then holding them accountable for improvement and
6 intervening is contrary to what the product exists for.
7 It's contrary to the very purpose of it.

8 Whereas somebody that enrolls in a closed system
9 has elected I'm going for a plan that's going to intervene
10 in the provision of care on my behalf, and holding them
11 accountable for how well they do that is entirely
12 legitimate.

13 So that's the broad distinction that I think
14 exists. But legalistically it isn't easy to put everybody
15 into those two categories for purposes of incentive payment
16 or mandates about quality reporting and improvement. So
17 it's a sticky wicket.

18 MS. ROSENBLATT: I have one other issue that we
19 sort of touched on when we were talking about the ESRD,
20 which is where does the money come from for whatever we do
21 on the incentive rate? Are you taking away or is it an add-
22 on?

1 When health plans generally add a quality
2 incentive, it's generally an add-on to what they are already
3 paying providers. And if, for example, Wellpoint were to
4 make a decision to pay a quality incentive, the minute we
5 made that decision we'd have to put up a reserve for that
6 and that money would be there.

7 My concern with the way the budget works is that
8 it's not like there is a fund and the money is there. I
9 just can't picture that and I'm just wondering if we need to
10 address that.

11 DR. HARRISON: I think that's also a decision up
12 for discussion.

13 DR. WOLTER: Glenn, I was just going to make the
14 point you did, and it might be worth reflecting that in the
15 body of the conversation, that there are some distinctions
16 going on with these different types of plans in terms of the
17 market forces that are driving choice, versus a plan that
18 really is -- maybe the expectation is out there that it will
19 try to do more to coordinate care.

20 And then I would also say that we might want to
21 recognize the fact that, at least as I look at some of
22 what's happening in quality right now, much of the emphasis

1 is on process measures of intervention which aren't captured
2 by claims data. Many of the things you mentioned are.
3 Some, such as the amount of time it takes for an antibiotic
4 to be given when somebody's admitted with pneumonia, or is
5 an antibiotic given within one hour of surgery, many of
6 those data elements would not be well captured in
7 administrative claims data.

8 And yet, they are becoming the focus some of our
9 leaders in the quality movement in some of the areas where
10 we can really improve quality outcomes and maybe improve
11 cost at the same time.

12 So I don't know whether we want to get to that
13 level of detail, but I think these are important
14 distinctions and probably would be part of our discussion
15 tomorrow on the quality chapter.

16 MR. HACKBARTH: Could you just briefly address,
17 Scott, the data collection mechanism for the HEDIS measures?
18 It isn't dependent or based exclusively on claims data.

19 DR. WOLTER: I assume plans could require other
20 things, also.

21 DR. HARRISON: I don't believe -- I believe it's a
22 survey that's often done.

1 MS. MILGATE: HEDIS is a mix of administrative
2 data and medical record extraction. The two primary
3 reporting tools are HEDIS and CAHPS. And CAHPS, of course,
4 is a survey. And that goes to both PPOs and HMOs. I don't
5 know actually if it's private fee-for-service, to tell you
6 the truth. But it definitely goes to PPOs and HMOs. And
7 then Medicare fee-for-service outside of Medicare+Choice.

8 HEDIS is a mix of administrative data as well as
9 medical record abstraction. CMS just recently, for the last
10 few years, have been doing an analysis of the parts of HEDIS
11 that, in fact, don't work very well for PPOs. There were a
12 few, and I'm not going to be able to tell you how many out
13 of how many measures. But it was a fairly -- it wasn't more
14 than maybe 10 percent of the measures that they didn't think
15 PPOs should have to collect data on. And those were the
16 ones that were medical record abstraction.

17 And those data go -- let's see, I'm thinking they
18 go to NCQA. I'm not sure if they go directly to CMS or
19 NCQA, but there's an audit process, is basically what I'm
20 trying to get at. Maybe, Nancy-Ann, you could even fill us
21 in.

22 But there's an audit process to make sure that

1 those data that are reported by the plan are accurate and
2 that's an independent audit, and then the data become CMS
3 data.

4 MR. HACKBARTH: That was the point that I wanted
5 to get to. We're not talking about using claims data or
6 administrative data exclusively. There are clinical data
7 involved but there is an audit process in place, which I
8 don't understand, but that there is one in place.

9 MS. MILGATE: I don't really know the details of
10 it but I know that the CMS actually certifies --

11 MR. HACKBARTH: It's a pertinent question because
12 here now we're talking about potentially adjusting payments
13 based on data submitted by plans. And ordinarily we like
14 the comfort of having some sort of a potential audit check
15 on that accuracy.

16 MS. DePARLE: I do know something about that.
17 When we first started collecting it in '97, we couldn't use
18 it because we did an audit and it had not been audited
19 before and it was pretty uniformly incorrect in the plan's
20 favor. So we decided we couldn't report that data. So we
21 went through a process with NCQA and the next year we had an
22 independent audit.

1 And I don't even remember who the firm was that
2 was being used. It doesn't matter, and they may use a
3 different one now. But I think it's an important thing.

4 And the plans are very corporate in that process.

5 DR. REISCHAUER: I think NCQA now has an audit
6 process, number one.

7 Number two, the Medicare+Choice HEDIS panel
8 doesn't include all the questions that private plans. So
9 it's a pretty truncated subset of the information that NCQA
10 collects for just commercial plans.

11 DR. WOLTER: I'm wondering if it would be a
12 reasonable request to get to some kind of a summary of what
13 is collected in the combo of those two things? Or is it so
14 voluminous it would be difficult to do?

15 MR. HACKBARTH: Absolutely. I think that's
16 important to have.

17 DR. REISCHAUER: It's apt to be on the website,
18 too.

19 MR. HACKBARTH: Any other questions or comments?

20 DR. WAKEFIELD: Sorry, Glenn, I think somebody
21 answered this, but the answer was lost on me.

22 Does draft recommendation three apply to private

1 fee-for-service or not?

2 DR. HARRISON: That's up for discussion. What do
3 you think?

4 DR. WAKEFIELD: So you haven't dealt it in or out
5 in your preparation?

6 MR. HACKBARTH: Do you have a preference? And if
7 so, why?

8 DR. WAKEFIELD: What would be helpful to me is a
9 little bit of a better understanding of how it could be
10 applied to that particular animal. You were talking about
11 choice. Of course, a lot of areas that have fee-for-
12 service, maybe they have private fee-for-service. They may
13 not have any other M+C available to them.

14 So when we think about quality, ensuring quality
15 for that beneficiary set, even though we're seeing some
16 retraction, but I think your document said that there are
17 some new private fee-for-service plans that have requested
18 review by CMS to enter the program.

19 So if that's the case and we see new plans coming
20 on deck, is this recommendation going to be applying to that
21 enlarging family or not of plans? I don't have a sense of
22 it because I don't exactly know how it would apply to that

1 type of plan.

2 MR. HACKBARTH: Let us spend some time thinking
3 through the issues a little bit for the January meeting and
4 we'll come back with some ideas on that. Anything else?

5 Okay, we're going to have a very brief public
6 comment period and then adjourn for lunch. As always,
7 please help us by keeping your comments short. I assure you
8 that you get more attention if you keep it brief and to the
9 point than if you go on. If someone in front of you has
10 made the same points or similar points, please be cognizant
11 of that and adjust.

12 MS. GAMBEL: Gwen Gambel, President of
13 Congressional Consultants. We represent a number of
14 dialysis-related clients.

15 I think this was the very best discussion I've
16 seen and I've been watching these meetings since ProPAC
17 began. Your level of knowledge has really increased and the
18 questions asked of Nancy, and the overall discussion, I
19 think has really improved. That was just a quick aside.

20 Getting to the points. We really would urge you
21 to use the CMS market basket rather than this jerry-rigged
22 one that was put together by ProPAC so long ago when there

1 was so much less data. The market basket that CMS put
2 together was put together by the same actuaries that put
3 together every single market basket, hospital, et cetera,
4 since CMS created market baskets or HCFA created market
5 baskets.

6 It has more input factors to it. It has better
7 proxies. And it really is such a better reflection. I
8 can't even understand why you would want to continue to use
9 one that was so jerry-rigged with one-third home health,
10 one-third SNF, one-third hospitals, the labor factors
11 projections when labor is 40 or 50 percent of costs. So we
12 really hope that you will seriously consider using that.

13 Secondly, I think the industry would be willing to
14 consider -- and I say consider -- being paid on quality
15 incentives but clearly not on a budget neutral basis. And
16 that's because we are absolutely inadequately paid. As Dr.
17 Rowe pointed out, we haven't had an update in 13 years. Our
18 first update will come in 2005, a measly 1.6 percent, which
19 is a little over \$1 per treatment. We're not talking big
20 bucks here when we're talking about these increases here.

21 We are really very, very disappointed about this
22 continued effort to have a productivity offset. As a

1 conditions of coverage we have nutritionists, a dietitian,
2 social worker, and this is wonderful. These are important
3 people in facilities. They are absolutely stretched to the
4 limit. You never find a dialysis facility with more than
5 one social worker or one nutritionist. These are so
6 important for patient outcomes.

7 Nutritionists sit down with every patient every
8 month and goes over their blood lab results and this is the
9 way to educate the patient so that they will be more
10 compliant and you will have better outcomes. And these
11 people are just stretched to the limit. So this is really
12 very bad for patient outcomes if you keep saying that
13 there's this room for productivity offsets.

14 The same with the social workers. The social
15 workers have to make sure that the patients get their meds,
16 they have to make sure that there's transportation for these
17 patients so they don't miss their treatments. These are
18 such critical people for patient outcomes. And yet, we only
19 have one of them in each facility because of this inadequate
20 reimbursement. So please think about these productivity
21 offsets.

22 And then we are really the only provider without

1 an annual update formula? And where's the justification for
2 that? I mean, would you think about hospitals not having an
3 annual update formula as part of their reimbursement?
4 Clearly not.

5 But we have to compete with these hospitals for
6 our nurses and for our technicians. We have provided Nancy
7 Ray with around the country where dialysis facilities versus
8 hospitals on what is paid and bonuses. Clearly, hospitals
9 can pay on average \$5 to \$10 more an hour for a nurse.
10 That's a no-brainer where the nurses are going and why we
11 have shortages and why the GAO highlighted the fact that we
12 have nurse shortages.

13 So we would urge you, please think about an annual
14 uptake recommendation in your recommendations this year,
15 because there's really no justification for us being the
16 only provider without an annual update formula.

17 Lastly, when we get to the adequacy of the
18 payment, we have provided on the table for you 2002 cost
19 report data which unfortunately Nancy did not get from CMS.
20 We had 70 percent of dialysis providers with their cost
21 reports providing 2002 data to Abt Associates. When Abt
22 Associates took that cost report data, they projected that

1 based on 2002 cost reports, our margins are 0.70 and our
2 payment-to-cost ratio of 1.003. This is total costs,
3 composite and drugs, on just the allowables. When we start
4 looking into some of the non-allowables, like full medical
5 director fees, we're below zero everywhere, margins as well
6 as payment-to-cost ratios.

7 So we're hoping, we see you're thinking about just
8 a 1.6 recommendation for 2005. Our projections show really
9 a 3.6 percent increase is needed. And again, it's in the
10 handouts. And I urge you to pick up the handout so that you
11 can go over those numbers.

12 Thank you very much.

13 MS. SMITH: Good afternoon, my name is Kathleen
14 Smith and I'm the Vice President of Government Affairs with
15 Frizentius Medical Care. We're the largest supplier of
16 items and services to beneficiaries with end-stage renal
17 disease.

18 I once was the President of the Fast Talkers of
19 America, Dr. Hackbarth, but I think your Commissioner, Dr.
20 Wakefield, has got me beat. But I think I can still manage
21 to be brief.

22 We have followed with interest over the recent

1 years and provided information with regard to end-stage
2 renal disease payment reform. And given the Commission's
3 history on that subject, and the fact that the recently
4 passed Medicare legislation does advance that process, I
5 would like to urge the Commission to make a third
6 recommendation in your report this March addressing that
7 topic.

8 Specifically, we urge the Commission to affirm its
9 recommendations to Congress that the need for accuracy and
10 transparency in rate setting in any new payment mechanisms
11 and to recommend that CMS reevaluate the difference between
12 and the relationship between current treatment costs and
13 payments. Specifically including the validity of outdated
14 cost report rules which result in the arbitrary disallowance
15 of certain truly necessary treatment-related costs.

16 As part of any serious reform effort it is
17 important that the baseline composite rate be revised to
18 reflect the full cost that we incur in furnishing dialysis
19 services. And further, that the rate be updated annually,
20 using a mechanism similar to the one that CMS just recently
21 developed as Ms. Gambel just commented comment on.

22 There is a precedent for taking this type of

1 position in payment reform and many of you lived through
2 this and remember it, but just by way of recollecting, when
3 the hospital PPS was implemented, hospitals were subject to
4 certain TEFRA-related cost limits. Those limits were
5 removed, however, in calculation of the PPS base rates. And
6 what I'm here to ask for is that something akin to that be
7 part of the ESRD payment reform mechanism.

8 I thank you for the opportunity to make these
9 comments.

10 MR. CINCHANO: Good afternoon. I'm Dolph
11 Cinchano, Vice President of the National Kidney Foundation.

12 As has been mentioned in Nancy's remarks and
13 remarks around the table, the National Kidney Foundation
14 Guideline Development Program is emblematic of our concern
15 for improving the parameters of care, not only in adequacy
16 of dialysis and anemia management, but also with respect to
17 nutrition, vascular access placement and preservation, and
18 in the area of bone disease.

19 I'd like to point out however that the performance
20 of dialysis facilities is not the only factor with regard to
21 outcomes in those three particular areas. With respect to
22 nutritional status of dialysis patients, the compliance with

1 dietary restrictions is only part of the issue. The other
2 half of the concern has to do with malnutrition, which is a
3 severe problem among dialysis patients and is implicated in
4 the hospitalization patterns of dialysis patients.

5 Dialysis facilities have limited ability to impact
6 on malnutrition. Medicare does not pay for most dietary
7 supplements and the Medicare policy for the most extreme
8 form of dietary supplementation, nutrition that is provided
9 during dialysis treatments is so restrictive that virtually
10 no patients qualify for it.

11 Similarly, the vascular access placement decisions
12 are made and should be made before the patient comes within
13 the care of a dialysis clinic. The National Kidney
14 Foundation Guidelines call for an increase in fistulas, that
15 is native vascular access, a decrease in grafts, and a
16 decrease in the use of catheters for vascular access.

17 Interestingly enough, Medicare payment, however,
18 provides an incentive for the use of graphs as opposed to
19 fistulas. So this is an area that perhaps the Commission
20 could address with respect to Medicare payment for vascular
21 access placement.

22 Finally, with respect to comments from Senator

1 Durenberger, the National Kidney Foundation and its 26,000
2 patient members are dedicated to empowering patients. But
3 one way to empower them is to provide them with additional
4 education opportunities. So we have been championing a
5 provision to create a new Medicare benefit to educate kidney
6 patients about their treatment options and their role in the
7 treatment process, and to do this education before they ever
8 come within a dialysis clinic.

9 There was a provision in S.1 which would've
10 created that benefit. It did not survive the conference,
11 however, so we will continue to advocate for that new
12 benefit.

13 And then lastly, with respect to whether or not
14 ESRD patients should be able to enroll in managed care
15 plans, we have traditionally opposed repeal of Section 1876
16 and, in view of the fact that that we have yet another
17 demonstration project that CMS is sponsoring which could
18 shed light on the value of disease management and managed
19 care for dialysis patients, I would recommend that
20 legislative change be held in abeyance until we see the
21 outcomes of that study.

22 Thank you.

1 MS. COWAN: Hello. Never wanting to stand between
2 hard-working people and a meal, I'll be very brief.

3 I'm Joyce Cowan from Epstein, Becker and Green,
4 and I represent Amsurg. So shift gears for a minute and
5 think about ambulatory surgery centers, which will be on
6 your plate tomorrow.

7 We've provided comments to the Commission in the
8 past and really appreciate the opportunity to do so today.

9 Amsurg is a large national company operating and
10 managing ASCs, over 110 in 28 states. So we think we'll
11 have a lot of experience that will be helpful as the
12 Commission goes forward in continuing to look at this
13 important area. I'm sure you'll be thoroughly briefed
14 tomorrow on the changes that Congress has made in this area
15 since your last set of recommendations last year. And I
16 think it brings a really exciting opportunity for MedPAC to
17 dig in and look at some of the complex issues with
18 ambulatory surgery centers.

19 In short, the Congress did three things,
20 basically. They more or less froze payment for the five
21 years. Two, they asked the GAO, if you recall from last
22 year's discussion, we've had a real shortage of data, direct

1 hard data, on ambulatory surgery centers charges, costs, how
2 they compare to hospitals, et cetera, et cetera.

3 So GAO will be looking directly at that and a
4 number of other issues with an end result game plan of
5 Congress giving HHS the authority to revise completely the
6 current payment system for ambulatory surgery centers, that
7 roll-out to be expected after the GAO report, somewhere
8 between '06 and '08.

9 So what we would urge the Commission to think
10 about, to help Congress plan to help HHS plan for that '06
11 to '08 roll-out. There are a lot of really complicated
12 questions in this area. What do we know about ASCs, how
13 large does Medicare payment policy, how large is that role
14 affecting ASC growth, practices, et cetera? Why are private
15 payers big fans of ASCs in many instances? A lot of really
16 intriguing questions that end up affecting, I think,
17 Medicare payment policy.

18 At Amsurg, with over 110 centers, we'd love to be
19 able to provide whatever experience. We've offered up some
20 of our local sites to staff to come out and visit and get
21 your hands around what's going on in ASCs.

22 I want to let you get to lunch, so I really

1 appreciate the opportunity to give some comments.

2 MR. HACKBARTH: We will reconvene at 1:30.

3 [Whereupon, at 12:42 p.m., the meeting was
4 recessed, to reconvene at 1:30 p.m., this same day.]

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1 AFTERNOON SESSION [1:51 p.m.]

2 MR. HACKBARTH: Cristina and Kevin, I think we're
3 going to go ahead. We'll have the remainder of the
4 commissioners coming shortly.

5 MS. BOCCUTI: Good afternoon. Kevin and I will be
6 presenting an assessment of payment adequacy and update
7 considerations for physician services. To help the
8 Commission consider its recommendations for physician
9 payments we will summarize the available evidence on
10 adequacy of current payment. Kevin will present two pieces
11 of this analysis. First an analysis of volume growth and
12 also a comparison of Medicare payment to private insurance
13 payment. Claudia Scherr is with us today and she's going to
14 be available to answer some questions on a new survey which
15 I'll be telling you about in a little bit. We're also going
16 to discuss expected cost changes and a draft recommendation.

17 To examine beneficiaries access to physician
18 services we consider several information sources. Surveys
19 that ask beneficiaries directly about their access to care,
20 data on physician supply, particularly with respect to
21 physicians who treat Medicare patients, and surveys that ask
22 physicians directly about their willingness to serve

1 Medicare beneficiaries. Overall, from surveys between 2000
2 and 2003 access is generally good for beneficiaries. A
3 small share of beneficiaries, however, do report some
4 difficulties obtaining access to physicians.

5 A large survey, the CAHPS fee-for-service survey,
6 provides some insight on beneficiary access to physician
7 services. The details of this survey will be discussed
8 tomorrow morning but I'm going to highlight a couple results
9 specifically dealing with physician access. Those results
10 are on this slide here. Beneficiaries are asked on the
11 survey if they have had problems seeing a specialist and 94
12 percent of beneficiaries said that they had small or no
13 problems seeing a specialist when necessary. Asked about
14 timeliness of scheduling an appointment for regular or
15 routine care about 90 percent said that they usually or
16 always received care as soon as they wanted. Note that this
17 survey gives us information only up to 2002.

18 To obtain more timely data MedPAC has begun
19 sponsoring small telephone surveys to beneficiaries. This
20 project is managed by Project HOPE which is where Claudia
21 helped us, and we have received results from an initial
22 round of this survey. We think of these results as giving

1 us some baseline information. I'm going to take a moment to
2 describe the survey since it's the first time we've used it.
3 I'm going to talk about the goals and limitations, but
4 Claudia Scherr is here to answer some technical questions if
5 they arise.

6 This survey is an attachment of a set of questions
7 to a larger consumer telephone survey conducted by a survey
8 research company. The survey includes a core set of
9 demographic questions in addition to questions sponsored by
10 other organizations. We sponsored 13 questions. The survey
11 was conducted recently, between September 17th and October
12 2nd, 2003. It took about three weeks to obtain a little
13 over 1,000 respondents who were Medicare beneficiaries age
14 65 or over.

15 The goals of the survey for us were to help us
16 obtain baseline results from its initial implementation and
17 then future rounds to give us an ability to monitor
18 beneficiaries' access to physicians services. But due to
19 sample size and response rate limitations a comparison to
20 other larger government-sponsored surveys with longer field
21 period may not be possible. So our analysis is cautious and
22 we see this mostly as a monitoring tool. The major

1 advantage of this survey is its timeliness and low cost.
2 Additionally, we can use this survey to assess beneficiary
3 response to other Medicare policy issues in the future.

4 So now I'll share some results from the survey.
5 These results are weighted to be nationally representative
6 with respect to basic demographic variables. So on the
7 slide you can see that we asked about beneficiaries' ability
8 to find a new primary care doctor. Ninety-three percent of
9 beneficiaries who were seeking a new physician reported that
10 they encountered small or no problems and only 7 percent
11 reported that they encountered big problems or were unable
12 to find a doctor. When asked about access to specialists,
13 similarly, 93 percent of beneficiaries who tried to find a
14 new specialist reported having small or no problems finding
15 one, and 5 percent reported big problems or were unable to
16 find a new specialist.

17 When asked about routine care and whether or not
18 they experienced delays in trying to schedule an
19 appointment, 71 percent of those beneficiaries who tried to
20 schedule an appointment for routine care never experienced a
21 delay, or that's what they reported; 21 percent said
22 sometimes and 8 percent said that they usually or always

1 experience a delay. For illness or injury-related needs,
2 beneficiaries' ability to schedule timely appointments was
3 better. Specifically, 80 percent of beneficiaries who tried
4 to schedule an appointment for an illness or injury never
5 experienced a delay, 16 percent sometimes and 4 percent said
6 they usually or always experienced a delay.

7 Because we're only interviewing Medicare
8 respondents this survey and all other ones that only
9 interview Medicare respondents, don't offer a comparison to
10 other insured populations across the United States so it's
11 difficult to determine whether or not access concerns for
12 some beneficiaries are unique to their Medicare status. For
13 example, market area trends in physician availability may
14 play a role in Medicare beneficiaries' ability to find
15 doctors and receive timely appointments. On this point,
16 older research from the Center for Studying Health Systems
17 Change found that between 1997 and 2001 both Medicare
18 beneficiaries and privately insured near elderly, -- that's
19 people between the ages of 50 and 64 -- encountered growing
20 rates of access problems. Results from this study were
21 discussed in our report last year.

22 Next I'm going to talk about some supply issues,

1 looking at supply issues that affect beneficiaries' access
2 to care specifically. Usually we provide you with updates
3 on the number of physicians billing Medicare. However, CMS
4 is in the process of re-examining their data on this so
5 we're unable to give you this information today for 2002.

6 But in using slightly less direct indicators of
7 the supply of Medicare physicians I've put up a chart here
8 that shows the share of physicians signing participation
9 agreements and the share of allowed charges paid on
10 assignment over time. In 2002, 99 percent of allowed
11 charges for physician services were assigned. That is, for
12 99 percent of allowed charges physicians agreed to accept
13 the Medicare fee schedule charge as the full charge. This
14 high assignment rate indicates that fee schedule amounts may
15 be adequate, at least when associated with the additional
16 benefits physicians receive when accepting assignment. This
17 high assignment rate may also reflect the high rate of
18 physicians who agree to participate in Medicare, which was
19 91 percent in 2003. Participating physicians agree to
20 accept assignment on all allowed charges in exchange for a 5
21 percent higher payment on allowed charges than non-
22 participating physicians.

1 We also examined physician surveys that provide
2 information on the proportion of physicians who are
3 accepting new Medicare patients into their practice. In
4 general, the most recently available data indicate that most
5 physicians are willing to accept new Medicare beneficiaries,
6 particularly those with a relatively large portion of
7 Medicare patients in their practice.

8 Smaller share physicians who report a reluctance
9 to serve Medicare beneficiaries may be responding to a
10 variety of factors other than or in addition to payment
11 adequacy. These other factors may include administrative
12 burden of Medicare, local physician supply, demand for
13 physician services, area market insurance conditions, and
14 the amount of time physicians are willing to devote to
15 patient care. So it's difficult to disentangle these
16 factors given the availability. Consequently, we're often
17 limited to physician responses to simple questions regarding
18 whether or not they are accepting Medicare patients.

19 The most recent survey information comes from the
20 National Ambulatory Medical Care Survey, or NAMCS as we
21 often call it. This survey is conducted in 52 reporting
22 period during the year, so that ensures that it's capturing

1 an even spread throughout the year. Results from this study
2 show that 93 percent of office-based physicians with at
3 least 10 percent of their practice revenue coming from the
4 Medicare accepted new Medicare patients. This number is not
5 significantly different from those reported on the 2001
6 NAMCS. We're hoping to get 2003 results in January.

7 Moreover, this finding is consistent with the
8 results of the MedPAC-sponsored survey of physicians that
9 Kevin talked about last year, and that was conducted in
10 2002. Ninety-six percent of physicians in that study who
11 were accepting any new patients and who spent at least 10
12 percent of their time with Medicare patients were accepting
13 new fee-for-service Medicare patients. But as you may
14 recall, the percentage accepting all new Medicare patients
15 was lower at about 70 percent. Earlier research from the
16 Center for Studying Health System Change showed that the
17 proportion of physicians accepting all new Medicare patients
18 fell at about the same rate as that for privately insured
19 patients.

20 Next is Kevin.

21 DR. HAYES: One other indicator that we look at of
22 the adequacy of Medicare's payment rates for physician

1 services is changes in the use of services by Medicare
2 beneficiaries, changes in the volume of services. The
3 thought here is that if we see decreases in volume that
4 could be a sign that Medicare's payment rates have become
5 inadequate. As we look at claims data through 2002,
6 however, we do not see decreases in volumes, at least among
7 the broad categories of services shown here. In fact we see
8 some pretty strong increases still in a couple categories of
9 services, as we have seen in the past, and that would be in
10 the categories of imaging and tests. On a per-beneficiary
11 basis the volume of imaging services went up by 9.4 percent
12 in 2002, and for tests the increase was 11.1 percent.

13 Within these categories we do see some decreases
14 in volume for selected services but it's not clear that the
15 decreases are a sign that payments have become inadequate.
16 In general, the decreases that we see are quite small or
17 they follow rapid increases in previous years. One
18 exception to all this would be a service like coronary
19 artery bypass grafts, however, and there the decrease was
20 just over 4 percent in 2002. Our interpretation of what's
21 happening there that we're just seeing some substitution of
22 the less-invasive coronary angioplasty procedures for the

1 more invasive open heart surgical procedures.

2 So bottom line on this indicator would be that we
3 don't see any evidence that the payments have become
4 inadequate.

5 If we look at our last indicator of payment
6 adequacy, this is something that we looked at last year. if
7 you recall, comparing Medicare's payment rates for
8 physicians services with average private insurers' payment
9 rates. The thought here is that if Medicare's payment rates
10 get too far below those of private insurers that some
11 physicians may choose to limit their practices to private
12 patients and not take Medicare's patients.

13 For this year we contracted with Chris Hogan at
14 Direct Research to update previous analyses to use claims
15 data through the year 2002. Recall in previous analyses we
16 had shown that the difference between Medicare's payment
17 rates and those in the private sector had narrowed. This
18 was through 2001 at a time when Medicare's payment rates
19 were growing at a relatively rapid rate.

20 In 2002, we see some slight widening of the gap
21 between Medicare and private rates. The figure for 2002 is
22 81 percent. So we're going from 83 percent in 2001 to 81

1 percent in 2002. The reason for this, a good part of it has
2 to do with the payment reduction that occurred in Medicare's
3 rates in 2002. Recall that the conversion factor fell by
4 5.4 percent in that year.

5 The gap would have been wider if not for a few
6 other things that happened. For one thing, Chris found in
7 analysis of the private data some drop in average private
8 insurers' rates. This was primarily due to a shift of
9 private enrollment from more generous-paying indemnity plans
10 toward other lower-paying types of plans.

11 Other factors at work here include the fact that
12 when we look at physician services we're including in the
13 definition of them not just physician fee schedule services
14 but also Part B drugs and laboratory services, and those
15 services did not experience the decreases that the physician
16 fee schedule services did in '02.

17 Finally on the Medicare side, there were some
18 offsetting increases in relative value units in the fee
19 schedule which slightly muted the effect of the conversion
20 factor change.

21 But anyway, putting all this together, we do see
22 some slight widening of the gap between Medicare and private

1 rates, but we're not by any means at the point we were in
2 the mid-1990s. As you can see here, the gap was much wider
3 where Medicare's rates were more in the range of 60 to 70
4 percent of private rates.

5 MS. BOCCUTI: I'm going to take you into the
6 second part of our adequacy payment framework, which is
7 changes in cost for 2005. There's two factors that are
8 important here, the input price inflation and the
9 productivity growth. The preliminary information on input
10 price inflation from CMS for 2005 shows an increase in input
11 prices of 3.2 percent. Within that total, CMS sorts the
12 specified inputs into two major categories: physician work
13 and physician practice expense.

14 Physician work includes salaries and fringe
15 benefits allotted for physicians, and that's expected to
16 increase by 3.4 percent. In the physician practice expense
17 category, what's included there are the non-physician
18 employee compensation, office expenses, professional
19 liability insurance, drugs and supplies, and medical
20 equipment. That is expected to increase by 2.9 percent for
21 the whole category. Within that, the PLI is expected to
22 increase by 4.7 percent.

1 As you know, to calculate these increases, CMS
2 uses weighted averages. Recently CMS rebased its input
3 category weights. These calculations resulted in a decrease
4 in the share of revenues going towards the physician work
5 component and an increase in the practice expense share with
6 an increase in PLI.

7 The other factor that we consider here is
8 productivity growth. Our analysis of trends in multifactor
9 productivity suggest an increase of 0.9 percent. We'll put
10 these two numbers together, the input price, inflation, and
11 productivity growth numbers in just a moment.

12 So to recap what we've said so far, we determined
13 that payments in general have been at least adequate though
14 some access problems may exist for some beneficiaries.

15 Now to discuss a draft recommendation for our
16 report, and this applies to the year 2005. In order to
17 determine payment adequacy in 2005 we need to make some
18 assumptions about payments in 2004. As you know, Congress
19 has acted to prevent a payment cut in 2004 and accordingly
20 payments in 2004 are likely to be adequate.

21 So the draft recommendation here is similar to the
22 one in the previous March 2003 report. That says that the

1 Congress should update payments for physician services by
2 the projected change in input prices less 0.9 percent in
3 2005.

4 To discuss the implications on beneficiaries and
5 providers, increasing payments for physician services would
6 help preserve beneficiary access to care. And increasing
7 payments to physicians would help to maintain the adequacy
8 of those payments and allow physicians to furnish high-
9 quality care.

10 Having recently received CBO's budget estimates
11 for the new act, we do not feel that we can confidently
12 predict the budget implication compared to the legislation,
13 so we will present budget implications of the Commission's
14 draft recommendation at the next meeting.

15 Thank you.

16 MR. HACKBARTH: Just for context can I ask you to
17 go over briefly the provisions in the reform legislation?
18 In fact let me ask you to just react to this
19 characterization. As I recall it was a 1.5 percent update
20 for each of the two years and then there were a series of
21 changes in some other provisions affecting physicians, many
22 of them directed as rural physicians, increasing payments to

1 rural physicians. Do we have a sense of what the aggregate
2 effect of the update plus the other provisions was in terms
3 of the total increase in payments, and how it would compare
4 to our recommendation?

5 MS. BOCCUTI: I'm going to turn that over to Kevin
6 who's been investigating some of that right now.

7 DR. HAYES: Relying on the CBO scoring of those
8 other provisions, they represent a total somewhere in the
9 area of less than 1 percent of total spending. So if we
10 couple the 1.5 percent increase in the conversion factor
11 with those additional more targeted spending increases we're
12 looking at a total increase in spending for physician
13 services somewhere in the 2.3 percent, 2.4 percent area.

14 MR. HACKBARTH: The aggregate effect of what
15 Congress did would be very similar to the effect of our
16 recommendation in terms of total spending but they've chosen
17 to distribute the dollars differently?

18 DR. HAYES: Yes.

19 DR. STOWERS: First I think it was a great
20 chapter. There was one thing or a couple two or three
21 things. One was this assumption that if physicians accept
22 assignment, or participate, or don't balance bill inferred

1 that that meant that they were satisfied with the payment or
2 whatever. I think I would make the case that the majority
3 of them accepting assignment has nothing to do with whether
4 or not the fee schedule is adequate or inadequate. It has
5 more to do with the incentives that are built into whether
6 to accept assignment or not accept assignment. The only
7 docs that do not accept assignment or those that are in
8 affluent enough areas that their patients can pay the bill
9 up front in those practices, because if they don't then the
10 patient has to pay the bill up front in the office because
11 the check is going to come from the Medicare at a much
12 delayed rate, sometimes two to three months later because
13 Medicare is not obligated to get the check out in a certain
14 period of time. Then the physician has to go collect the
15 money then later from the patient, and it's at a reduced
16 rate and you'd have to go through all of this trouble, and
17 in the end the physician ends up with less money in the end.
18 Just all the collection problems and all the other things
19 that happen. So that's why 98 percent of physicians accept
20 assignment. It has virtually nothing to do with the payment
21 schedule being enough or too little or too much.

22 So I really think it's an inappropriate confusion

1 of whether or not Medicare is paying enough or too much for
2 services in this chapter, as to whether or not physicians
3 are accepting assignment or not. It's all these other
4 incentives, in other words, that are forcing --

5 MS. BOCCUTI: Right, the additional benefits.

6 DR. STOWERS: The incentives have been built in
7 there by Medicare for many years to force docs into
8 accepting assignment. It has nothing to do to with --

9 MS. BOCCUTI: And I didn't even mention all the
10 additional benefits. I did in the chapter, I tried to. So
11 I will make that very clear, that there are added benefits
12 that may be weighted heavily in a physician's decision to
13 accept assignment.

14 DR. STOWERS: I really question whether this
15 accepting assignment ought to even be in this chapter at
16 all. Because we're looking here at the adequacy of payment
17 in Medicare and I don't see a place in the chapter for
18 accepting or not accepting assignment.

19 MR. HACKBARTH: So from your prospective it goes
20 more to the question of beneficiary liability, and it has an
21 effect there, but it doesn't reflect that the Medicare
22 payment rates are adequate.

1 DR. STOWERS: Right, it has nothing to do with
2 that.

3 DR. HAYES: If I may, it would just be that we
4 have traditionally used this indicator as a complementary
5 indicator with the information that we don't have yet,
6 admittedly, on the number of physicians billing the Medicare
7 program. So when we put all of this together we have a
8 picture of whether or not physicians are continuing to
9 accept Medicare patients and an indication of what the
10 financial liability is what for the beneficiary, which is an
11 indicator of access, which we do consider access as one of
12 our payment adequacy indicators here.

13 So in the interest of putting together a complete
14 picture of what it's like for the beneficiary to make use of
15 physicians services we felt like there was some value in
16 putting it in there.

17 DR. STOWERS: I'm okay with what's in the box that
18 says, it may have something to do with the balance billing
19 part and the access to the patient and that's truly pretty
20 insignificant because it only makes up 1 or 2 percent of the
21 physicians out in the field. But then you turn around and
22 made the statement that because most of the physicians

1 accept assignment than the payment rates must be okay. That
2 statement I feel is -- that's an inappropriate --

3 MS. BOCCUTI: The conclusion is what --

4 DR. STOWERS: That conclusion is inappropriate
5 because there's lots of other things driving the fact that
6 physicians accept assignment versus going the non-
7 assignment, rather than the fact that they're being paid
8 enough by Medicare.

9 Nick might have other thoughts about that than I
10 do. So I just don't think we can jump to that conclusion.

11 MS. BOCCUTI: I understand.

12 MS. ROSENBLATT: I just want to ask a question
13 about the Chris Hogan survey and the graphs that you showed
14 that was about 80 percent. That's based on actual claims
15 data and it's based on comparing Medicare fee schedules to
16 what a private insurers might pay an under-65 population
17 most likely, correct? Refresh my memory, does that include
18 capitated payments? I wouldn't think so. Or does it?

19 DR. HAYES: Yes, there are HMO claims on the
20 private side.

21 MS. ROSENBLATT: HMO claims, but not capitation.

22 DR. HAYES: No.

1 MR. HACKBARTH: So it's just payment -- fee-for-
2 service claims.

3 MS. ROSENBLATT: There's no capitation in there?

4 DR. HAYES: Correct.

5 MS. ROSENBLATT: So if it's HMO, it's an HMO
6 that's paying on a fee-for-service basis?

7 DR. HAYES: That's correct.

8 DR. NELSON: I may have misunderstood what you
9 said but with respect to the 2004 update I think you said
10 that Congress has legislated a small update so we assume
11 that payments were adequate for '04 in projecting for '05?

12 MS. BOCCUTI: Right, in that what Glenn was
13 bringing up earlier in getting a sense of aggregate
14 payments. But before the act there was a pay cut that was
15 slated to occur.

16 DR. NELSON: I understand all that. I guess the
17 point that I want to make is that we came up with a
18 recommended update for '04 that was based on inputs less a
19 productivity factor and Congress's actions ought not to
20 necessarily negate that, at least until we have experience
21 that tells us whether that update was adequate or not. The
22 presence of legislation that may redistribute that within

1 various portions, rural versus urban or whatever, doesn't
2 detract from the fact that that indeed may not be an
3 adequate update for large portions of the population
4 receiving services. Until we can develop some data on '04 I
5 wouldn't want to see us assume that that was an adequate
6 update until we know that it is.

7 Even reflecting on '05, I think we ought to be
8 consistent with the same process and try and estimate as
9 accurately as we can what the input costs will be, less a
10 productivity factor, which I've never agreed that we use the
11 right metric for that. I wonder if there is a productivity
12 for the service industry as opposed to industry that
13 produces products, in labor statistics. I don't know that,
14 but I'd like to find a way to refine the productivity better
15 than just taking a shot at 0.9. But that's a different
16 issue.

17 So the point that I want to make is, let's word
18 our recommendation for '05 so that our reference to '04 is
19 consistent with what our recommendation has been and the
20 process that we followed in arriving at it.

21 MR. HACKBARTH: Maybe we ought to jump ahead and
22 just look at the language --

1 MS. BOCCUTI: The background that I said on 2004 -
2 - 2004 is not necessarily in the draft recommendation.
3 That's background.

4 MR. HACKBARTH: Right. So based on the measures
5 of adequacy that we review, we have no data suggesting to us
6 that what was done in '04 was inadequate. On the other
7 hand, we have no information, as you're pointing out, to
8 specifically bless it as adequate. So we're silent on that
9 and the recommendation language is directed only towards
10 '05.

11 MR. MULLER: If we could go back to the chart that
12 compares the physician -- thank you.

13 In some of our other provider chapters we often
14 make a comparison of Medicare margins versus total margins
15 and I think as a policy we have basically said that we
16 should not use the Medicare program to support margins that
17 are less than adequate from other payers. I think it might
18 be useful -- this is obviously a provider sector in which
19 the Medicare program pays less than the private market,
20 though I'm sure if we had a Medicaid slide up there it would
21 show it pays more than Medicaid on average.

22 But I think for the sake of consistency it would

1 be useful to show that in fact this is one area in which, if
2 one could use such a margin calculation -- we don't do it as
3 much with physicians as we do with other providers because
4 of the difficulty of calculating physician margins -- but
5 this is an area in which Medicare in a sense could be said
6 to pay less than the private market. We in a sense have a
7 higher margin elsewhere and one could -- what I'm suggesting
8 is it's the total margin elsewhere that is supporting the
9 Medicare margin being less. I think if we're going to make
10 that point consistently in those areas where the Medicare
11 margin is higher than what is paid by private payers and
12 other providers sectors, I think we might want to suggest
13 the reverse here. That in fact there is some support going
14 on of physician income from the private payers. I wonder,
15 Kevin, if you want to comment on that.

16 DR. HAYES: I don't know about support of
17 physician income without knowing the unknowable, which is
18 what their costs are. That's the difficulty that we face in
19 this sector is not having a good measure of costs. So I
20 don't know where Medicare is relative to their costs
21 otherwise. So our goal here with this has been, as you can
22 see with this slide, is to just look at trends over time and

1 see how Medicare compares to the other payers. But implicit
2 in this is a recognition that we can't get at that further
3 issue of the cost comparison.

4 MR. HACKBARTH: In fact I think I would be
5 uncomfortable with the notion of saying this slide shows
6 some cross-subsidization of one payer by another. I think
7 the relevance of these data are -- we're looking for
8 potential harbingers of access problems for Medicare
9 beneficiaries. The notion is that if these numbers get too
10 far out of whack it could be a harbinger that problems are
11 on the way for beneficiaries. So it's an indicator that
12 we're looking at as opposed to a commentary on the relative
13 subsidization of one payer by another.

14 DR. REISCHAUER: Let me jump in just because I
15 want to talk about this table here, and some of the things
16 Ralph had said. Kevin, I guess I just didn't focus on the
17 fact that this included, I think you said Part B drugs and
18 lab tests. My guess is, relative to physician services
19 narrowly defined, the fraction over time accounted for by
20 lab and prescription drugs applied in the office have grown.
21 The numbers are pretty small but I wonder if you could do a
22 what-if on the weights.

1 I'm looking at this table that you have, and I
2 know we discussed this before, and looking at lab tests
3 which is an infinitesimal section of the total, but a 16.9
4 percent growth in one year. Bells would go off if this were
5 bigger. I just can't imagine what's bringing about a
6 service utilization growth in one year that is that great.
7 We have the drug thing, as I said. This trending upward
8 that we have could really be an artifact.

9 DR. HAYES: So we need to do some sensitivity
10 analysis I guess and see what the effect is without those
11 other factors. Hold on one second.

12 DR. REISCHAUER: Don't tell me you have it.

13 DR. HAYES: Chris is pretty good and he did this -

14 -

15 DR. HOGAN: Page 5.

16 MR. HACKBARTH: Chris, why don't you come up?

17 DR. HOGAN: Good point. I wish I'd thought of it.
18 Page 5 of the report, I took them out and it didn't make any
19 difference in that ratio. It was almost 15 percent of the
20 spending total when I got all the little odds and ends take
21 out. So 85 percent of what you see up there really is the
22 services of physicians, 15 percent is other stuff. But it

1 turns out the pricing differential was not all that
2 different for the other stuff versus the physician services.
3 Put it in, take it out, I get that last bar, that 2002 bar
4 is at the same spot.

5 MS. RAPHAEL: I just wanted to share with
6 commissioners a conversation that I had with Mark and Kevin
7 and Cristina and some of the things that grew out of that,
8 because I have been approached by a number of people who
9 have been telling me that they believe in their area of the
10 country there are access problems that are being
11 experienced. This is all fairly anecdotal. It's not at all
12 based on any kind of national review of the issue.

13 But in discussing this with Kevin, Cristina, and
14 Mark and Bob Berenson in a conversation this week there were
15 a number of things that I guess I hadn't been as aware of.
16 One is that there are differences in marketplaces
17 attributable to dependence on Medicare. Because if you're
18 in a particular specialty like ophthalmology that is very
19 dependent on Medicare you're less likely to reject Medicare
20 patients than if you're in specialty where you actually can
21 select from a broader population. I think that is something
22 that we need to take a look at.

1 Secondly, one of the points that was made based on
2 some recent information which maybe Chris can comment on,
3 was that actually there's a broader gap between private
4 payments for specialists and Medicare payments for
5 specialists than there's for primary care and general
6 practitioners, which I also had not been as aware of. I
7 think, Mark, we agreed that we were going to take some steps
8 to try to get at this beneficiary access issue over the next
9 few years. But you may also want to comment on --

10 DR. MILLER: Just a couple of comments on this.
11 Last year when we went through this same analysis -- and
12 refresh my memory if I'm wrong, we did disaggregate by
13 specialty and IM, GP types of physicians and did make this
14 point about specialists, that the gap between the specialist
15 payments in private and Medicare is larger than it is
16 between the primary care and IM types. In a conversation
17 with Bob Berenson what was interesting was that what he was
18 finding was, or what he was arguing in some marketplaces is
19 almost counterintuitive. That it's much easier to get
20 access to a specialist -- and some of it is because they are
21 very dependent on Medicare types of patients -- and that the
22 issue, the bottleneck was more among primary care

1 physicians, and that some of what was happening is that the
2 patient presents and the primary care are not spending the
3 time to go and do the evaluation and management. It's just,
4 your leg hurts, you go to the leg specialist. Your head
5 hurts, you go to the head specialist. You can tell how
6 technical I am on all this. That was the argument.

7 What we got into was discussions of relative
8 payment within the fee schedule, is the longer run issue.
9 Kevin or anybody like that should comment if there's a piece
10 of the conversation I missed.

11 DR. HAYES: No, that's it. The interesting thing
12 for me in that conversation was that there's clearly more
13 involved than just payment rates. If it's a matter of a
14 narrow gap between Medicare and private rates for primary
15 care services, yet that seems to be where the beneficiaries,
16 at least from anecdotal reports, is where they're having the
17 most difficulty. Then you figure there's perhaps some other
18 more macro, system level factors at work here having to do
19 with just overall demands on the primary care physicians
20 from all patients, not just Medicare patients. So it's a
21 complex thing.

22 DR. WOLTER: Kind of a process interpretation

1 question related to something Alan raised, if the new
2 legislation has, what is it, 2.4 percent increase for
3 physicians?

4 DR. HAYES: 1.5 for physicians.

5 DR. WOLTER: If the total when you add in the GPCI
6 and other things it's closer to 2.3 or 2.4, and our
7 recommendation comes out at whatever it comes out at, how
8 does that get interpreted, and do we make any comment on
9 that? Because there could be the thought that we're right
10 on with the recommendation coming out of MedPAC in terms of
11 the legislation. Others might say, there was an update
12 recommended and that should be on top of the total that's
13 perhaps in the legislation; this distributional issue that
14 Alan raised. Is that something we just stay silent on, or
15 how do we deal with those questions?

16 MR. HACKBARTH: The reason I raised it is I think
17 that the explanation is important. On how people will react
18 to it I'm less certain. But I didn't want people to say,
19 MedPAC recommended 2.3, Congress did 1.5; they're at odds.
20 I think it's more complicated than that. Congress did
21 essentially the same thing in terms of increasing aggregate
22 expenditures for physician but chose a different

1 distribution of the payments. I don't think we're -- we
2 could decide to comment on that distribution and say that we
3 think Congress distributed it properly or improperly.
4 That's an option open to us.

5 But the first order analysis is just that the
6 aggregate dollars are about the same and I wanted people to
7 understand that. I think that is an important statement for
8 us to make.

9 DR. WOLTER: That was a good point. Of course
10 another option would be that we think the update needs to be
11 whatever it needs to be and that's a separate question from
12 GPCI adjustments or whatever, and those would be additional
13 dollars. There would be several options in the
14 conversation.

15 MR. MULLER: We've done the physician update based
16 on kind of a marketbasket equivalent.

17 DR. MILLER: The only thing I was going to say
18 about commenting on the bill, it's happened fairly recently
19 and whether, at least from an analytical perspective of
20 being able to express an opinion about it would have
21 involved a fair amount of work. First understanding it,
22 modeling it, and determining what the distributional impacts

1 are, and then a discussion of whether we agreed with them or
2 not. I can tell you for certain, our ability to do that
3 between now and January is going to be pretty much zero. So
4 it will be hard to make an analytical statement about
5 whether we agree with what they've done.

6 MR. HACKBARTH: That would not foreclose our, in
7 the future, looking at the GPCI changes and the like and
8 offering an opinion on whether those were a good thing or
9 not. But then the other side of the coin and the one I
10 think Nick is getting at is that, arguably, you're saying
11 that there should be a 2.3 percent increase and then the
12 GPCI and all that stuff on top of it. That would be another
13 way to go.

14 DR. WOLTER: I was just envisioning the
15 possibility after you raised it and then Alan followed up
16 that those might be conversations that would occur over the
17 course of the year.

18 MR. HACKBARTH: I guess the way I would like to
19 leave it is keep our recommendation framed in terms of the
20 overall update, and I think the 2.3 percent is about the
21 right to number. If we wish to come back and address some
22 of rural provisions that were added I think we need to do so

1 in a careful and thoughtful way and January isn't sufficient
2 time to do that. We can come back to it later.

3 DR. REISCHAUER: I guess I sort of have the
4 feeling that if the 1.5 percent is significantly lower than
5 what we suggested for a general update we should make some
6 nod in that direction and not pretend that money that's
7 going to be concentrated on a very small fraction of the
8 physician population really is there to take care of the
9 general problem that's out there. I'm not sure that we do
10 this with sufficient precision so that when the general
11 update is a few tenths of a percentage point below or above
12 where we recommend that we then leap from our chairs and
13 say, good Lord, inadequate payments; we have to do
14 something. I think you can write this in a non-
15 confrontational, non-judgmental way.

16 MR. MULLER: Glenn, just to go back to the point I
17 was making earlier, this is a provider segment in which we
18 do not do our usual two-part test. Basically we use
19 measures of access as a proxy that the base is adequate. I
20 understand why it's difficult to get a calculation of
21 physician revenue and cost, but basically in the other
22 sectors, whether it's home health, SNF, hospitals, et

1 cetera, we do make some calculation of adequacy before we do
2 our update, and obviously here we don't. Maybe we should
3 say, we don't do it here because it's too complicated to do,
4 but basically use the access measure as a proxy for adequacy
5 rather than actually calculating it.

6 MR. HACKBARTH: Access is a part of the framework
7 for all providers so it's not unique to physicians that we
8 look at access. But it is in fact true that we have no data
9 on margins, because we have no information on physician
10 costs. So that's an empty hole in our framework for
11 physicians, which I think maybe makes it even more important
12 that we look at the access number.

13 I also think the physician market -- I haven't
14 thought this all the way through so bear with me. But I
15 think that the physician market may have a little bit
16 different dynamic than some of the other provider sectors.
17 I think Medicare's market power is less for physicians, at
18 least some specialties of physicians than it is for
19 hospitals. It's very difficult for a hospital to walk away
20 from the Medicare program, except in rare circumstances.
21 But for some physicians and some specialties where Medicare
22 is a very low, or a much lower share of their revenue,

1 walking away or not accepting new Medicare patients is much
2 more of an option. We hear anecdotes that in fact some
3 physicians are exercising that option in particular parts of
4 the country.

5 So I think paying particular attention to how
6 Medicare rates compare to private rates and any other
7 indicator of access is especially important for physicians.
8 The sensitivity may be even greater there.

9 DR. REISCHAUER: Kevin, I think you said that to
10 the extent that there appeared to be difficulty in accessing
11 care it was more with primary care physicians than with
12 specialists. I would think that that's what one would
13 expect because specialists have a much higher turnover of
14 patients during a year, so in a sense there's more openings
15 than a primary care physician who might have very low amount
16 of turnover, so the probability of one going and seeking an
17 open slot is always going to be less.

18 MR. MULLER: It's more clinical, Bob. It's
19 basically that people who need specialists are old. I mean,
20 35-year-olds by and large don't need specialists. It's more
21 of a clinical indicator -- specialists have more Medicare
22 patients than primary care because they're the ones who need

1 specialists and because 35-year-olds don't need them.

2 DR. NELSON: They may have a rapid turnover but
3 they may have a longer queue. But to get back, I think it's
4 important for us to retain the distinction between the way
5 we tried to estimate an update that would take into account
6 input prices and try and keep pace with inflation, on the
7 one hand and Congressional action that was intended to
8 entice people into underserved areas. It has a different
9 motivation and a different reason. It doesn't make sense to
10 commingle those and just say, it all adds up to about the
11 same number, it must be okay, because they have different
12 purposes.

13 MR. HACKBARTH: So what we want to avoid is
14 implied endorsement of the distributive policy.
15 We want to make it clear that we think the appropriate
16 update is the 2.3 percent. That's the message, right? Then
17 if we wish to look at the distributive issues later on we
18 can do that as a separate matter when we've got more time
19 and opportunity.

20 DR. MILLER: I'm really reluctant to do this with
21 this many people in the room, and Kevin, if this is way off
22 base -- I mean, part of the nervousness I had about thinking

1 through the distributional stuff in a short timeframe is I
2 myself, and many other people, I think were carrying around
3 the notion that these physician dollars were targeted to
4 small areas and small groups of physicians. Yet if you look
5 at some of the scoring, there's a fair amount of dollars
6 that are traveling through some of these mechanisms. So
7 exactly how far out they're going to reach is something of a
8 question.

9 Now if I'm way off base here, Kevin, you need to
10 correct this. But this is part of what we're starting to
11 unpack. I walked into this legislation thinking there was a
12 whole bunch that went to underserved areas. I think that's
13 the general intention, but the definition of the area is at
14 least not clear to me at this point. And like I said,
15 there's a fair amount of dollars traveling through this.

16 DR. HAYES: One way to add to what Mark said is to
17 think about the new bonus payments, the new 5 percent bonus
18 payments. They apply to areas with the lowest physician to
19 beneficiary ratios such that the cumulative beneficiary
20 enrollment in all such areas that are eligible for this
21 bonus equals 20 percent of Medicare enrollment. That's a
22 pretty large percentage of the beneficiary population.

1 One observation we had at the staff level was that
2 25 percent of beneficiaries live in rural areas, so this is
3 a pretty large -- now granted, not all of those
4 beneficiaries stay in those places and receive care there,
5 but it just gives you some idea of breadth of some of these
6 provisions.

7 DR. STOWERS: On page 23 you got a little bit into
8 the PLI -- and I don't mean to get off into this PLI thing
9 altogether because it's -- but you talk about the projection
10 of 4.7 percent, or 6.6 last year and then it went to 16.9.
11 I only make the point that if we're talking access to
12 beneficiaries, Oklahoma went up 44 percent last year and we
13 got hit with 80 percent this year for the average physician
14 in increased premiums. That's probably going to affect
15 access more than the basic fee schedule in Medicare,
16 especially in a lot of our specialties, neurosurgery and
17 emergency medicine and that kind of thing.

18 I would like to see you develop this text box
19 maybe a little bit more to show, maybe the word was
20 sensitivity to which Medicare is going to respond to
21 particular specific geographic areas and specialties to
22 carry its part of this crisis that's happening around the

1 country.

2 In other words, if I'm a specialist providing care
3 to Medicare beneficiaries, what percentage of that increased
4 hit is going to be covered by Medicare in this formula, and
5 in what timeframe is that going to be covered? In other
6 words, is there some assurance, if I read this MedPAC
7 report, that the Medicare fee schedule is going to respond
8 to my problems? I think that plays a big role in whether
9 I'm going to stay a participant as much as what the actual
10 amount I'm getting paid for a particular procedure.

11 MS. BOCCUTI: I see what you're saying. What's in
12 the text box explains that there is really two mechanisms
13 for dealing with the PLI. You bring up the one that is more
14 sensitive, which is the fee schedule. It's more sensitive
15 to specialists and to geographic areas because its
16 differential in that way. Whereas the MEI's capture of the
17 PLI is not, so that's all over.

18 But I think the point that you're trying to make,
19 and make sure I understand you correctly because you're
20 talking about addressing this in the chapter, is to draw
21 some conclusions about adequacy and access with relation to
22 the PLI. I see what you're saying in that we didn't really

1 say that this may or may not to affect access and how. But
2 we did show the example of a Detroit neurosurgeon who is in
3 an area that has high PLI.

4 DR. STOWERS: I'm just trying to quantify it. One
5 of our surgeons jumped from \$20,000 a year two years ago to
6 \$85,000 in premiums and 50 percent of his practice is
7 Medicare. Is his Medicare reimbursement going to increase
8 that 50 percent in between to cover his --

9 MS. BOCCUTI: We'll try to make that clear.

10 DR. STOWERS: Do you see what I'm saying?

11 MS. BOCCUTI: Yes.

12 DR. STOWERS: It would be nice if that's explained
13 in here, that the Medicare formula is going to take care of
14 what's happening to him in that particular community in
15 Oklahoma.

16 MS. BOCCUTI: Or How it does.

17 MR. HACKBARTH: Of course it won't address it for
18 every individual physician and every circumstance.

19 DR. STOWERS: I understand that.

20 MR. HACKBARTH: But I do recall in the November
21 materials there were some examples of the power of the
22 interaction of the two factors, the MEI component plus the

1 specialty-specific geographic --

2 DR. STOWERS: We could go a little further maybe.
3 Thank you.

4 MR. DURENBERGER: I really don't intend my
5 comments to change any of the wording in the decision but
6 I've just finished going all over the state of Minnesota and
7 North Dakota because I'm chairing a governor's citizens
8 forum and so forth and there's very little in here, if I
9 took this around Minnesota with me, that would reflect the
10 reality of what's going on in -- I mean, if I sat down with
11 physicians there's very little in the nature of this
12 presentation that would reflect the realities of what's
13 going on in Minnesota today. I don't mean that as a
14 criticism because I know we have a particular way of having
15 to approach the updates.

16 But I hope between now and the next time we
17 address this that we would spend a little bit more time
18 talking about how the practice of medicine is changing in
19 this country, about how the variation in practice actually
20 leads to variation in the deployment of various kinds of
21 doctors in a wide variety of communities. I'm sure Nick
22 experiences this as we do across our part of the country.

1 If I asked people in Minnesota today, doctors in
2 Minnesota today, what's the greatest problem with Medicare
3 payment, they would say the disparity between the financial
4 rewards for primary care and the financial rewards for
5 specialty care, because of financial rewards for specialty
6 care are driving subspecialty hospitals, ambulatory surgery,
7 all that sort of thing, driving people out of general
8 hospitals in rural as well as Twin Cities type areas into
9 other parts of the country. I've told you this before, we
10 now have 38 heart hospitals in two states, two relatively
11 low populated states, Minnesota and Wisconsin and only three
12 of them meet HEDIS requirements. That's the tip of the
13 iceberg.

14 The point simply being that there's more to the
15 payment formula than the annual update across the board. I
16 really think that at some time we need to deal with that.

17 There are other issues like shortages. We have a
18 lot of health profession shortages in our state. To the
19 extent that it's ancillary health professionals you are
20 loading more work on the primary care doc, whether it's
21 nurses or whatever the case may be, dentist, a whole lot of
22 other people.

1 There are specialty shortages that are really
2 interesting that relate to what goes in and out of the
3 education pipeline. There was a time I was told the other
4 day, there was a time in the late '90s in which
5 anesthesiologists in our state were making about -- to come
6 to work for our hospital, were making about what nurse
7 anesthetists were making, just over \$100,000. The last
8 anesthesiologist hired by a hospital in Minnesota got paid
9 \$400,000-some. It's a reflection on a marketplace.

10 I don't know that we're all that different from a
11 lot of other places in America. I just think the markets
12 are changing fairly substantially. There's nothing very
13 static about them. All that means is that within the
14 context of a broad-based adjustment for Part B there are a
15 lot of other things going on that affect beneficiary access.
16 So I'm merely saying that I think we owe it at some point to
17 the professions out there to do not just the update but to
18 try our best to describe how and why the payment formula
19 plays some role in either facilitating positive practice
20 changes or as a barrier to the kind of changes that ought to
21 take place.

22 MR. HACKBARTH: I think a considerable piece of

1 the reform legislation changes in physician payment were
2 directed at the geographic issues and the difficulty of
3 attracting physicians to certain parts of the country. Now
4 whether they did it right, went far enough or too far, again
5 I don't have any opinion on that and I think that's a
6 subject we can come back and look at. But that's certainly
7 one of the pieces of commentary that --

8 MR. DURENBERGER: But to me that's the old command
9 and control thing, as some of my more conservative friends -
10 - in other words, we have no way of deciding -- the people
11 that decide that are people like Nick Wolter, Roger
12 Gilbertson who runs Merit Care, which is a huge organization
13 up in Fargo. Those are the people that -- they have to g
14 out and pay \$400,000 for a subspecialist, or some other
15 people, who may get paid a lot less in the Medicare program.
16 But they're making those decisions today simply because it's
17 important to put certain kinds of combination of primary and
18 specialty services in certain communities.

19 In our neck of the woods, the nature of practice
20 often addresses shortages better than doubling the payments
21 to public health doctors or something like that. So I'm not
22 arguing with the fact that there wasn't an effort to do

1 that. I'm just saying I think docs do a better job usually
2 of doing that than does the reimbursement system.

3 MR. HACKBARTH: Bear with us for a second because
4 I want to make sure that I'm understanding what you're
5 saying. There are several factors that influence
6 beneficiary access to physician services, which is
7 ultimately our goal is. Only one of them is the update. In
8 this conversation we're focused principally on the update
9 factor.

10 A second is the geographic formulas for adjusting
11 payments. We're not taking that up here, but again, that's
12 something that we very well could delve into and offer some
13 recommendations in that area.

14 A third is the specialty differentials that you
15 alluded to at the outset. If I understood you correctly
16 you're saying you still think that specialists are paid too
17 much relative to primary care.

18 MR. DURENBERGER: I'm reflecting what others say.

19 MR. HACKBARTH: I think we've gone a considerable
20 distance over the last decade in reducing those disparities.
21 I'm agnostic on whether we've gone far enough or too far,
22 but that is a variable that the program has played with

1 substantially over the last decade. So we've not ignored
2 that one by any stretch.

3 DR. MILLER: Just so you know, this question and
4 the question that we were talking about with Bob Berenson is
5 the same type of question. And just so you know, the staff
6 isn't dead in the water on this. Kevin has been doing some
7 work with Bob Berenson and some of his colleagues. This
8 work is complicated and takes time, but we do have a path to
9 address some of these issues, correct, Kevin?

10 DR. HAYES: Yes.

11 DR. MILLER: The review of the impact of the fee
12 schedule and how it's affected the mix of funds between
13 primary care and specialty.

14 DR. HAYES: Yes.

15 MR. HACKBARTH: What we could do in the run-up to
16 this discussion which will focus principally on the update,
17 just make sure it's clear that we understand that there are
18 other moving parts in this system that have a bottom-line
19 effect on beneficiary access.

20 I think we've covered everything there. Anything
21 else, Cristina, Kevin? All done? All right, thank you very
22 much.

1 Next up is home health.

2 MS. CHENG: During my time with you I'd like to do
3 four things. I'm going to take just a moment to review some
4 of the information that we've already had concerning payment
5 adequacy. I'm going to introduce some new information on
6 beneficiary access to care, the volume of home health
7 services, the quality of services, and the margins. Then
8 I'll consider changes over the coming year. And finally,
9 we'll have your discussion of the draft recommendation.

10 To review briefly, the conference report reduces
11 the marketbasket update by 0.8 and restarts the rural add-on
12 at 5 percent. Both changes will occur halfway through
13 fiscal year 2004. In October we discussed some evidence
14 that access for most beneficiaries to this benefit is good.
15 Geographic access includes 99 percent of the beneficiaries.
16 Ninety percent of the beneficiaries surveyed reported little
17 or no problem in obtaining care.

18 We've also seen that the supply of agencies in
19 terms of the number of Medicare-certified home health
20 agencies has risen slightly since the implementation of the
21 PPS. Good access and a rising supply of agencies both
22 indicate that payment is at least adequate.

1 Because of continuing concern about access to care
2 we have pursued this question further with two additional
3 studies. In June we contracted with Chris Hogan of Direct
4 Research to look at claims data and demographic information
5 of the Medicare beneficiaries. We found that during the
6 period of decline in home health from 1996 to 2001 the
7 greatest declines occurred among users with the least well-
8 defined needs for skilled care. That is, when we compared
9 the diagnoses of users before and after the decline we found
10 that users with markers of frailty and chronic conditions
11 such as COPD or chronic heart failure had the greatest
12 decline while those who could conceivably be restored or
13 recover under home health care, such as strokes or hip
14 injuries had smaller declines.

15 This change is consistent with the change in the
16 focus of the benefit from the continuing care of chronic
17 conditions to the recovery from illness or injury. We also
18 found that users in the highest use states had greater
19 declines.

20 In a separate study, Nancy Ray used a national
21 survey of home health providers about the demographic and
22 clinical characteristics of their patients. We found that

1 the older-old and the more functionally disabled used the
2 benefit in greater proportions in 2000 than they did in
3 1996. Use by female beneficiaries as a proportion remained
4 about the same.

5 In both of these studies there is no evidence that
6 these vulnerable populations have been systematically
7 excluded from this benefit over this period.

8 In the recent past volume has been particularly
9 volatile in this benefit. Some of these changes in volume
10 reflect differences in the volume of users, which rose from
11 '92 to '96 and then fell during the IPS and the initial year
12 of the current payment system. Other changes in volume
13 reflect changes in the product that is home health, the
14 number of visits per episode, the mix of visits by visit
15 type, the typical length of stay for a beneficiary from the
16 time that they were admitted to home health to the time they
17 are discharged from home health.

18 In 2002 and the first half of 2003, rapid
19 reductions in the number of visits per episode and the
20 length of stay have slowed. Perhaps the current average of
21 18 visits per episode, which showed almost no decline over
22 2002 and the first half of 2003, will continue. The length

1 of stay in home health actually ticked upwards slightly
2 between 2001 and 2002. That's another sign that the trend
3 of shorter episodes with fewer visits may be ending.

4 The changes in the mix of visits have also
5 continued, but at a much slower pace as we've seen therapy
6 continue to become a slightly larger proportion of the total
7 number of visits in terms of the mix of visit types. If
8 payments were not adequate we would expect the decline in
9 volume to continue. That would be consistent with the
10 product change and the incentives of the PPS which is a
11 capitated system. However, the steadying of these volumes
12 suggests that payments perhaps are adequate.

13 To pursue this a little further, we analyzed a 5
14 percent sample of claims to count the number of unique
15 beneficiaries annually using this benefit. The volume of
16 users has fallen in the past according to the CMS trend that
17 I've shown on the left hand here. From our analysis on the
18 right hand, the number of users appears to have increased
19 between 2001 and 2002. We will continue to monitor the
20 volume of users. Based on the change from 2001 to 2002, the
21 evidence suggests that payments are at least adequate to
22 incent providers to take on some new beneficiaries.

1 Another piece of new information that we have
2 regarding the adequacy of current payments is a measure of
3 the quality of outcomes of care. This graph displays be
4 pre- and post-PPS measure of quality for home health. This
5 score was developed for MedPAC by Outcome Concept Systems.
6 It summarizes clinical and functional improvements as well
7 as adverse events for all the beneficiaries in the national
8 OASIS database. We use the scores on the OASIS patient
9 assessment at admission and then we compared them to the
10 scores at discharge. Patients received a two for
11 improvement, a one for stabilization, and a negative one for
12 a decline, or for one of four sentinel or adverse events
13 that occurred during their stay in home health.

14 As you can see, the median score from 1999 to 2002
15 is virtually the same. Now this is based on 100 percent of
16 the OASIS assessment so it is a real difference, but you can
17 see that the difference is smaller than the standard
18 variation in 2002.

19 Since the quality has remained the same, that adds
20 an important context to two important indicators in our
21 framework. We can see that beneficiaries have had the same
22 access to the services that they need before and after the

1 PPS because their outcomes have not declined. Also since
2 quality has remained the same we can conclude that the
3 decline in the cost per episode is a real increase in
4 productivity rather than substituting an inferior product.
5 We also looked at the severity of patients and we can also
6 conclude that it's not a substitution of less severe
7 patients for more severe patients because the severity of
8 patients at the beginning of their care in these two years
9 rose from 1999 to 2002.

10 The final new piece of new information that we
11 have on payment adequacy are the margins. One of the issues
12 that we had last year was a somewhat smaller sample of cost
13 reports than we would have liked. This year we have some
14 real improvements in our cost report data. I want to
15 genuinely thank the folks at CMS who not only processed all
16 these cost reports in a very timely manner at the same time
17 that they were making a tricky transition from one type of
18 database to another. We appreciate the efforts that they
19 made to make this data available. As a result of their hard
20 work we now have 3,500 cost reports, and that's
21 substantially all of the annual cost reports for
22 freestanding agencies with Medicare costs and payments

1 greater than zero.

2 This year we were able to use a full fiscal year
3 sample of cost reports. They did not span the
4 implementation of the PPS, and thus we've avoided a cost
5 allocation problem. The cost reports that spanned the
6 implementation date appear to have underreported their costs
7 under the PPS compared to our newer, complete sample. This
8 cost allocation did affect our sample last year but it will
9 not have an impact on our future samples of cost reports.
10 Because our latest data is also newer than it was last year,
11 we were able to use a large sample of fiscal 2002 cost
12 reports to measure the trends in cost between 2001 and 2002.

13 So using this new sample we have derived our
14 estimate and projections of the Medicare freestanding home
15 health agency margins. The aggregate projection for 2004 is
16 16.8. This number does reflect the provisions of the
17 conference agreement.

18 We also had an opportunity to look at the margins
19 by type of control of the agency. You see that voluntary,
20 for-profit agencies had a lower margin than the private
21 agencies, and government had a somewhat lower margin than
22 that. We also compared the margins of urban and rural

1 agencies and this is by the location of the agency. The
2 2001 estimate includes the rural add-on that was in place at
3 that time that was 10 percent for the entire year. The 2004
4 projected estimate includes an add-on of 5 percent that's in
5 place for half a year.

6 As you can see, in 2004 the urban and rural
7 margins moved somewhat closer together, and the rural is
8 somewhat lower than the urban. However, we also looked at
9 this in terms of the caseload of the agency and when you
10 compare agencies with 100 percent urban caseload to agencies
11 with 100 percent rural caseload, the rural caseload agencies
12 are slightly higher again than the urban; the same
13 relationship that they had in 2001.

14 In summary of this table, the aggregate margin of
15 17 percent would appear to be more than adequate payments
16 for the Medicare costs.

17 Now I'll move to changes that we expect over the
18 coming year. The marketbasket which measures changes in
19 input prices is 3.1. However, evidence suggests for this
20 sector that productivity and product change will offset the
21 increase in prices. We base that on our observation that
22 cost per episode fell 10 percent from 1999 to 2001 and they

1 continued to fall between 2001 and 2002. We have estimated
2 for the purposes of our model that they will not rise over
3 the coming year.

4 We also have evidence that scientific and
5 technological advances will continue to proliferate. Some
6 agencies have only made these investments and given their
7 potential it seems likely that they will continue to diffuse
8 throughout the sector.

9 The two most important scientific and
10 technological advances that we have seen for this sector is
11 the increased use of electronics in the home, such as
12 bedside monitoring and diagnostics, and the use of negative
13 pressure or hot wound therapy. Both of these therapies have
14 evidence that show that they can enhance quality in studies
15 from journals such as the Annals of Vascular Surgery and the
16 Journal of Dermatology. It is also found that better
17 monitoring can catch problems like weight change faster
18 which should improve the outcomes for beneficiaries.

19 These technologies can increase prices in the long
20 term, but those same studies generally found that they would
21 improve productivity because they can decrease the number of
22 visits necessary per episode to treat a wound or to monitor

1 a patient.

2 In our framework, evidence of upcoming scientific
3 and technological advances could lead us to recommend an
4 update that's slightly larger than otherwise. We do find
5 that this sector has limited access to capital, but we also
6 note that they've had several years of large, positive
7 margins which ostensibly could have been used to make the
8 advances in these scientific and technological advances.

9 Which brings us to the draft recommendation.
10 Taking into account evidence that current payments are at
11 least adequate or more than adequate, as well as evidence
12 that payments will continue to be adequate over the coming
13 year the following draft recommendation has been developed.
14 That Congress should eliminate the update to payment rates
15 for home health services for fiscal year 2005.

16 The spending implication would be to reduce
17 spending compared to current law, and given our evidence we
18 conclude that the beneficiary and provider implications
19 would have no major implications for this sector.

20 At this time I'd like to get your discussion of
21 the draft recommendation.

22 MR. HACKBARTH: I know Carol has a comment but

1 could I just ask a question, Sharon, about the preceding
2 slide? The second bullet says productivity and product
3 change will offset the increase in prices. Earlier you had
4 made the point that one of the forms that much of the
5 product change took early on was the reduced number of
6 visits per episode. If I understood you correctly, that has
7 leveled off now, so that aspect of product change may have
8 run its course.

9 But you're still saying that notwithstanding the
10 fact that fact that the visits per episode is flat that you
11 think the productivity and product change will offset the
12 increase in input prices? Am I understanding you correctly?

13

14 MS. CHENG: The change in the model that I made
15 between this year and last year was that last year I used
16 the evidence that I had that the product was changing and
17 that costs were going down to actually project that costs
18 would continue to go down. This year I see that the costs
19 did go down between '01 and '02, and I don't see evidence
20 that the product change is going the opposite direction so
21 I've modeled that they will not increase but I have not
22 modeled that they will continue to decrease. So I actually

1 have a cost change of zero.

2 MR. HACKBARTH: I'm not sure I follow.

3 DR. MILLER: For just one second let me try and
4 clarify this. I'll take responsibility for this. We talked
5 about what words to put in here. I think the point -- and
6 make sure I get this right, Sharon -- is that we continue to
7 observe a reduction in cost per episode. We didn't find the
8 drop in the visits like we had previously so we weren't
9 quite sure to attribute what this reduction in cost was to.
10 So we were, what should we be saying here, and I think I
11 said, just put productivity and product change since we
12 don't know what was really driving the reduction in the
13 cost. But we did continue to see -- I hope I'm getting all
14 this right -- a drop in cost. We just didn't see the drop
15 in visits like we had in previous years.

16 Then her last comment is, in order to be
17 conservative we didn't assume that their costs declined in
18 forecasting forward, we just assumed that they would be
19 flat. Is that fair, Sharon?

20 MS. CHENG: Yes.

21 MS. RAPHAEL: I just want to enlarge the payment
22 issue here and take it a little beyond just the question of

1 the payment update, because this is two years now since
2 we've introduce the prospective payment system for this
3 sector and I think we've seen effects on reductions in
4 utilization. We've seen effects on the types of patients
5 who are receiving the benefit. We've seen, I believe, very
6 serious changes in payer mix. We've seen changes, I think,
7 shift of site of care and effects on out-of-pocket costs for
8 beneficiaries. Lastly, I think we've seen some effects on
9 access.

10 First of all, I think that one of the areas that
11 I'm very concerned about is if I see that it is advantageous
12 to change your payer mix so that you have a higher Medicare
13 percentage, pure Medicare percentage. Because for example,
14 an organization like mine that has one-third of our patients
15 who dually eligible, that group of patients in fact have
16 much lower margins than those that are only Medicare
17 beneficiaries. In fact the irony of it is that that group
18 of patients have a lower case mix index. You can say, how
19 can that be? And they use more services.

20 So the way that the OASIS and the whole
21 categorization and scoring occurs is that you don't really
22 get a different score for being somewhat dependent or

1 totally dependent, and it's not a good predictor of the use
2 of paraprofessional services. So my average Medicare-only
3 patient they have nine home health aide visits. For dually
4 eligible they 23 home health aide visits, even though that
5 category has a lower case mix index. So that that group is
6 a much higher utilizing group. Whether it's because they
7 are poorer, more likely to be disabled, less likely to have
8 caregivers, I don't know all the reasons. I certainly have
9 no clear information, I just have my own experience to draw
10 from here.

11 But one of the concerns that I have is that I
12 think -- and I just was speaking to one of the Wall Street
13 analysts who had called me and he told that one of the
14 companies in the last quarter had increased their Medicare
15 share by 11 percent in one quarter. So that you can have a
16 gravitation toward taking only Medicare beneficiaries and
17 you can really impair organizations that take dually
18 eligibles, because it is much less advantageous to take that
19 segment of the Medicare population. I think that we have to
20 really look at the implications of payment on access and
21 future access for that particular group.

22 In addition to which, I just continue, and Sharon

1 knows I feel this way, not to agree with the conclusion that
2 the focus of this benefit has changed, and that it what
3 Congress intended. That we focus on people who have had hip
4 fractures and that we don't focus on people who have cardiac
5 conditions, congestive heart failure or pulmonary disease.
6 The norm for people over 80 is they have chronic conditions
7 with acute exacerbations. It's not just the norm that they
8 have an acute injury or an acute illness. The norm is quite
9 the contrary. This benefit should be for people who have
10 chronic conditions with acute exacerbations. I don't think
11 that we're looking to change that.

12 When we say that we comfort ourselves that the
13 decline has been for those who have a less clear and defined
14 need for home health care, that is those who have pulmonary
15 disease and congestive heart failure, I don't take great
16 comfort in that because that's a group as much in need as
17 the group that's had a fall. So I'm very concerned about
18 drawing that sweeping conclusion which we draw.

19 We look at utilization in 2002 and we also draw
20 comfort, all is well with the world, because the same number
21 of people are utilizing the benefit in 2002 as did in 1992.
22 But guess what, I think there were 37 million Medicare

1 beneficiaries in 1992 and now there are 40 million and the
2 proportion of those over 85 has increased. So I don't draw
3 great comfort from that either. So I really think we need
4 to spend some time taking a look at these issues.

5 Now I know you quote this one study, the National
6 Home Care and Hospice Organization study, but I believe that
7 the National Institutes of Health Statistics suspended that
8 study because they thought that it wasn't a good survey and
9 they're really trying to recast that study. If you look at
10 the Health Affairs article in September and October by
11 McCall and Murtaugh, they say that basically the probability
12 of getting home health care for the 85 and over has in fact
13 declined between '99 and 2001.

14 So I think there are some very important issues
15 there that we need to pay attention to. I'm not even
16 talking about uncompensated care, because I, for example,
17 this year have seen 8,000 cases that have no insurance. And
18 I don't get any DSH payment for seeing uncompensated care
19 cases in the current system. So I'm not even raising that
20 because I know DSH has another set of issues attendant to
21 it.

22 But I do think we have to ask ourselves what kind

1 of agencies do we want to ensure are there in the future so
2 that we have broad access for all parts of the population
3 here, and that we don't have incentives in the system that
4 lead you to go only in one direction.

5 In the June report we had made a statement that we
6 thought there was some shift of site of care to nursing
7 homes and some substitution for home health care. We also
8 have had a principle that we really believe that any
9 substitution should be on clinical grounds not on payment
10 grounds. I think we need to go back and look at that,
11 because I don't know why that substitution is happening and
12 why nursing homes have grown in terms of the number of
13 patients and home health care as a sector has declined. So
14 I just think that's another important area.

15 I have issues around productivity but it's
16 probably not too much different from my other colleagues who
17 have expressed it, but I know we're like a tertiary care
18 center in home care. You talk about the vacuum pressure and
19 heat in wounds. Less than 3 percent of our wound care
20 patients are getting that, and we have the most broadly
21 disseminated technology. You can use it for surgical
22 wounds, you can't use it for vascular wounds. You have to

1 have a caregiver to do the dressings.

2 Sharon, you attended this big colloquium we had of
3 all the agencies who are involved in a big quality
4 initiative, and it's infinitesimal how many of them actually
5 have computerized. It's an aspiration. It's not an
6 actuality.

7 So I just think that I don't see this productivity
8 gain that we're purporting here. I see it in the
9 literature. I don't see it yet in practice.

10 DR. WAKEFIELD: A couple of comments -- and
11 actually I think you touched on it, Carol. I was wondering
12 about where -- and maybe we did address this somehow in the
13 June report because you seem to allude to it -- where the
14 users with least well-defined needs are described, those
15 with chronic care problems, CHF, et cetera, where then now
16 are they getting their care? Are they getting their care?
17 Do we have any sense of that? If the benefit has shifted in
18 terms of what's being covered then what's happening to that
19 patient population in terms of that particular care need?

20 I'd only say just as an anecdote, there was an
21 article that appeared in our local newspaper just within the
22 last week about a Medicare beneficiary who was being seen at

1 home for congestive heart and they were using a phone and
2 access long distance using telemedicine technology, and the
3 numbers of hospitalizations of that particular beneficiary -
4 - now that's an anecdote of one -- but it had dropped
5 significantly as that patient was being followed at home,
6 and in fact long distance at home than the previous year.
7 So it was touting the benefits of telemedicine, but also the
8 point being made that that was a patient that was not using
9 inpatient services to the extent that he had in the previous
10 year.

11 So I'm wondering about that. Where are those
12 patients, those Medicare beneficiaries getting their
13 services and how are those being paid for? Just as a
14 question. Perhaps you can't answer it.

15 Then secondly, we've got a chart that talks
16 about Medicare freestanding home health agency margins but I
17 don't know what's happening with hospital-based home health
18 agencies. I don't know what the distribution of hospital-
19 based home health agencies rural versus urban. I don't know
20 what they are but my guess is that we tend to see a fair
21 amount of them in rural areas -- at least that's what I hear
22 from my rural hospitals -- that when they don't have

1 anything else they've got to -- in order to ensure that
2 there's some provider of home health agencies it falls to
3 the hospital as the last person or entity standing in the
4 community to provide that service.

5 So could you give us a breakdown of what might be
6 happening with hospital versus freestanding on home health,
7 just as we've seen that with SNF, for example, the hospital
8 versus freestanding SNFs? I guess that was probably my
9 second and last point, because it looks like our
10 recommendation applies to all home health services in both
11 of those categories but I'm only seeing margin data on one.

12 MS. CHENG: That was a decision that we actually
13 made in looking at the cost reports. We do find that the
14 freestanding home health agencies were 68 percent of all
15 agencies in the program, 70 percent of all Medicare
16 payments, and 67 percent of all episodes. So they are the
17 majority of the providers in the program.

18 When we looked at the distribution we didn't see
19 substantial differences in the distribution of freestanding
20 and hospital. I can give you more detailed breakdowns on
21 exactly how they pair up. But we felt that the cost
22 allocation issues that are common to all of the hospital-

1 based units seemed especially to hit home health agencies
2 that are hospital-based. So we felt like the biggest
3 difference between hospital-based and freestanding was the
4 cost allocation that the hospitals made more than a real
5 difference in their performance. So is not quite apples to
6 oranges which is why we don't lump them together.

7 DR. WAKEFIELD: We always add the wraparound
8 language about cost shifting within hospitals. But if
9 you're talking about the similarities with this, to say
10 inpatient versus outpatient margins, if that's you're
11 saying, but we also have at least historically always looked
12 at those and then inserted that caveat. Are you saying
13 these numbers would be so murky and so misleading that it's
14 not worth even taking a look at what those margins are for
15 the inpatient --

16 DR. MILLER: I think the answer to that is that
17 we're going to move into the hospital section next, but at
18 this point we don't have -- we'll have for the January
19 meeting hopefully, we have an aggregate margin for the
20 hospitals. We're not going to be able at this point to
21 detail the allocation within hospitals and even break down
22 hospital types at this point. We just aren't that far in

1 the analysis. You're point is taken but we're not going to
2 be able to present it at this meeting.

3 DR. REISCHAUER: Just on that point, do we have
4 any information about the closing of hospital-based home
5 health agencies? Because if they're growing or they aren't
6 shrinking, then one might conclude that it's not a bad line
7 of business to be in.

8 MS. CHENG: There's a table in your materials on
9 page 7 that gives you a breakdown of the agencies by type.
10 In '98, freestanding were 72 percent of the agencies,
11 facility-based were 28 percent. And if you read that across
12 it's 70/30 and then it/s 72/28 again in 2002. So as a
13 proportion of the sector it stayed essentially the same.

14 MS. BURKE: I don't mean to be repetitive but I am
15 as concerned as Mary about what this suggests about our
16 capacity to evaluate the impact of a no update for the
17 hospital-based facilities as compared to the freestandings.
18 I also very much agree with Carol, I think there are a whole
19 series of issues about home care. I agree with Carol, I
20 don't think that we intended that the nature of the service
21 change, or the nature of the patient that we serve change to
22 the exclusion of people that we had cared for traditionally.

1 Our capacity to care for people at home has clearly changed.
2 Our capacity to introduce technology has allowed us to care
3 for people that years ago when I was in practice we couldn't
4 have cared for in a unit.

5 Having said that, I don't think it was to the
6 exclusion of the chronic patient. I worry about a
7 presumption that in fact, all things being equal, that there
8 is no increase needed because of the margins we see that are
9 based on the presumption that we're changing the nature of
10 the patient.

11 I also am sensitive to Mark's point, which is that
12 we can't easily examine the hospital and how a hospital
13 allocates costs. But I think to suggest that in the absence
14 of that information we presume that this kind of an update
15 makes sense for hospital-based units who may face very
16 different kinds of circumstances is risky, and it concerns
17 me. Yes, we have remained relatively stable but that
18 occurred after a period of time where there was a shift away
19 from hospital-based to freestanding. All the changes in
20 terms of the way we financed home care that occurred in the
21 '80s and '90s led to a dramatic increase in the number
22 overall and a shift towards freestanding.

1 But I am very concerned that we look carefully at
2 hospital-based as an individual set of institutions rather
3 than presume that this answer is the right answer for that
4 segment, because I don't think we really do know what the
5 impact will be, nor the nature of that in terms of the kinds
6 of patients that they serve.

7 DR. STOWERS: I just want to echo a little bit
8 about what Carol was talking about. On page 6 you mentioned
9 that we maybe needed to look into the fact that there was a
10 decrease in home health aide visits, and then in the chart
11 on page 10 we see that it dropped from 50 percent of the
12 visits down to 23 percent of the visits. In our practice, I
13 just want to try to describe what that's really interpreted
14 to.

15 When we have chronically ill, 80-year-old patient
16 that's had an acute episode of congestive heart failure and
17 they become debilitated from it, it used to be that five to
18 six days a week they got a bath, and someone came in and
19 changed the sheets and took care of the home. Now in we're
20 really lucky I can get someone into the house to do that
21 twice a week since the PPS has come into effect. So that's
22 the state of the health or cleanliness of that patient at

1 this point because those aides, they're just not there any
2 more. That's if we can get them at all. I would say half
3 of our agencies don't have aides at all anymore. So that
4 has fallen on the families, if they have a family to do
5 that, and most family members are not either mentally or
6 physically prepared to come into the home and do that kind
7 of care and lifting and that sort of thing.

8 So when that structure breaks down, what's
9 happening is they're going into the nursing home earlier,
10 not because we don't have a great physical therapist or
11 great nurses or that kind of thing, but they are diverting
12 off because the patient is left in an unclean situation and
13 an unhealthy situation with a poor diet, no one to cook
14 their meals for them. This may only need to be done for a
15 two or three or four-month period until they can get back on
16 their feet out of this acute episode that's happened in
17 their chronic medical illness because home health is now
18 geared up for a post-fracture or post-hip surgery or
19 whatever that we weren't geared up for in the mid-'90s.

20 So I really think we need to look further at this
21 structure of care because we're concentrating on high
22 skilled nursing care and physical therapy and all that, but

1 what keeps these people at home is often the lower-skilled
2 individual that just give them the basic of everyday care
3 that they need, which we had before. It's been a drastic
4 change in the type of care of these patients in their homes
5 since -- just in the last two or three years. It's
6 something to see on a daily basis and their quality of life.
7 So I just wanted to make that statement.

8 DR. REISCHAUER: I have a lot of sympathy for
9 Carol's plight, but I don't see that it has much relevance
10 to the update issue. What we seem to be saying is, there
11 appear to be quite healthy margins in every component of
12 this industry that we can ascertain now when we slice it and
13 dice it by urban and rural, and voluntary and private, and
14 so on. We don't have the hospital cut yet but maybe we'll
15 have it in January. So in the aggregate there's enough
16 money but the payment system within that aggregate is biased
17 in favor of the high skill type of care and what we need to
18 do is redress that imbalance, and there's plenty of money to
19 do it.

20 MS. RAPHAEL: Plenty of money to do it? I don't
21 think there's plenty of money to do it, because if you have
22 a high proportion of Medicaid, which I didn't even raise for

1 the reason of trying to be consistent here. But if you have
2 a high proportion of Medicaid and you have a high proportion
3 of dually eligible, either you're in a rural area, inner-
4 city, wherever, there isn't plenty of money. There's only
5 plenty of money if you change the mix of your patients, and
6 I think that's more important than utilization per patient.

7 DR. REISCHAUER: I'm not talking about plenty of
8 money within your agency. What I'm saying is within the
9 system. So those agencies that are doing a whole lot of the
10 high-end type of home care would receive less and it would
11 be shifted to those of you who didn't. But a 16 percent
12 margin strikes me enough to walk around the neighborhood
13 with.

14 MR. HACKBARTH: The other side of that coin is
15 that the update factor is a crude tool to deal with the
16 problems that you're talking about because it would increase
17 payments to agencies that have carved out a very healthy,
18 profitable niche. Sort of the blunderbuss approach to
19 fixing the problem. But if I understand your point
20 correctly, this is a distributive question. This is a case
21 mix question, are we fairly allocating the dollars we've got
22 as opposed to is there enough money in the system in the

1 aggregate?

2 MS. BURKE: I'm not sure it's just case
3 mix, Glenn. I think that could well be. Bob's point is
4 right, there's probably enough money in the system. There
5 is an aspect of it that is case mix in terms of what the
6 distribution of patients look like. But I do worry that is
7 still doesn't really answer, and perhaps we will be able to,
8 the nature of the hospital issue and the freestanding issue,
9 which is -- I don't know what that looks like. It may have
10 the same kind of margins, but I don't know that, and I don't
11 want to presume that one location is in fact the same as the
12 other. In fact it may be a case mix issue, it may be a
13 geographic issue, but I don't know that without seeing what
14 the a hospitals look like.

15 MR. HACKBARTH: On the face of it I would have
16 thought that the allocation issues between inpatient
17 hospital and home health may be somewhat less difficult than
18 a service like hospital-based SNF, because you're talking
19 about a business that is direct labor costs. They're
20 operating, by definition, outside the hospital, not sharing
21 facilities and the like, so the allocation, the accounting
22 issues presumably would be less than for some other

1 services.

2 MR. MULLER: If I can just, based on the
3 discussion we're having here about whether with the
4 perspective payment now we have some incentives, whether
5 it's Ray's anecdote of the frequency of visits and so forth
6 that causes people to flip back into institutional settings.
7 Maybe you can refresh our memory as to the average cost of
8 home care per year and do some sensitivity analysis of if X
9 percent of these patients flip back into an institutional
10 setting, whether it's hospital or a nursing home and so
11 forth, what does that cost us in terms of the institutional
12 costs versus what we're saving in the home care.

13 I think just having some kind of sensitivity chart
14 in there, for example, let's say if a hospitalization is
15 five times as much per year as a home care visit, then -- as
16 Glenn said earlier, you shouldn't do your arithmetic in
17 public too many times -- but basically if it costs you five
18 times as much when they flip, then if 20 percent of the
19 patients, to use that loose term, flip over from home care
20 into an institutional setting, what kind of savings are we
21 securing in terms of the program? Just do that kind of
22 comparison, that would help.

1 I think, to go to Sheila's point briefly and
2 Carol's as well, we've said a number of times and I raised
3 the point earlier around physician payments, we try to just
4 look at the margins inside the Medicare program and not look
5 elsewhere. But obviously if you have a lot of Medicaid then
6 in fact, like in Carol's caseload and perhaps some of the
7 rural caseloads, you have less margin to be able to do the
8 kind of things, to have the kind of amplification of
9 services that when you run a more -- when you run a home
10 care program that's largely Medicare that has these kind of
11 margins. So what in fact may happen is you tend to skimp
12 more because you're cross-subsidizing the Medicaid, and
13 therefore that may have an effect on the Medicare program if
14 you're skimping on some of these services that cause people
15 to get back into the institutional setting.

16 So again I fully understand why we don't want to
17 get into saying we should use the Medicare program to cross-
18 subsidize other programs, but if it has the effect of some
19 skimping in the program because of cross-subsidy in Medicaid
20 that then costs money to Medicare, if that isn't too long a
21 sequence of argument, that's something I think we should be
22 at least attentive to as to what the cost trade-offs are.

1 MR. HACKBARTH: Sharon, can we bring some data to
2 bear on the issue of patients be readmitted to hospital or
3 SNFs from home health? Some trend data, what is happening.
4 That might be a metric worth tracking.

5 MS. BURKE: Glenn, could I just add to that? It
6 would also be interesting, and I'm not sure whether we do
7 know this, but what proportion of patients receiving home
8 care are who are duals as compared to the general
9 population. Is there a disproportionate number? Because
10 that would also help us fully understand Carol's point, if
11 in fact the number is greater than the number you find in
12 the general population or against -- they tend to be high
13 utilizers anyway. They tend to be more costly as a general
14 matter. But I wonder if there's a disproportionate impact
15 on home care. I don't know that there is but it would be
16 interesting to know if there are any kind of data that tells
17 us who it is that's using the service, which would give us
18 some sense -- the case mix would pick up a little bit of
19 that but not entirely.

20 DR. REISCHAUER: But the real question is, how has
21 that changed over time?

22 MS. BURKE: True, absolutely.

1 DR. REISCHAUER: Which is what you want to know.

2 MR. SMITH: Building on Ralph's point, it would
3 also be useful it seems to me, in going back to Carol a year
4 ago, is what is the admission rate of the folks who are no
5 longer receiving home care at all? That population, Sharon,
6 that you described as the users with least well-defined
7 needs, people with chronic multiple needs but who don't have
8 something which fits more neatly into the way the PPS
9 affects who ends up in home care in the first place. The
10 problem may even be bigger, Ralph, than I think you were
11 suggesting.

12 The other question, I think we have changed the
13 benefit. We've changed it, in fact even if we didn't intend
14 to, Sheila. Technology has changed the benefit a little but
15 the PPS changed the benefit because it created a different
16 set of incentives for providers. I do think the burden of a
17 lot of this conversation is not whether or not Congress
18 intended to do something stupid but whether or not Congress
19 did something that has had a set of consequences which we
20 didn't intend. We've come back to this point in this
21 conversation now for three years in a row. It seems to me,
22 Mark, that it is useful to try to figure out how to get a

1 handle on that.

2 The question -- it's not the precise way that we
3 ought to frame it, but the question is, is there a benefit
4 out there which used to be provided, maybe profligately and
5 unwisely but in some cases usefully, which is not now being
6 provided? And what are the consequences of that? What are
7 the health care consequences? What are the admission
8 consequences? What are the bounce back consequences to the
9 Medicare program? All of those questions lurk in the
10 background of this discussion and we've never made any real
11 progress at getting at them. I'd like to see if we could
12 try somewhat systematically.

13 MS. DePARLE: In response to your question, I
14 think I remember that the Inspector General at HHS and
15 perhaps even the GAO looked at, or tried to look at the
16 question of readmissions among people who had been in home
17 health or were no longer able to access home health. This
18 was part of the immediate response to the decline in the
19 number of agencies in some parts of the country after the
20 BBA and the interim payment system. I don't remember the
21 results of that but I think there may be some data at least
22 from that period.

1 But in response to David and to some of the other
2 discussion we've had today, certainly I think the data that
3 we've seen and that we looked at last year reflects a more
4 significant decline than most people thought would occur in
5 utilization of home health as a result of the policy changes
6 that were implemented in the BBA. But I think we need to
7 remember that there was in fact a concern that the benefit
8 was being overutilized and wrongly utilized and a number of
9 the policy changes that were made were designed to address
10 that, and to make some changes in the beneficiaries who
11 received the benefit. Some of that was the concern about
12 the homebound requirement, and I don't think that's even yet
13 been resolved.

14 But beyond that there was a concern about the
15 policy that was implemented to require the physician to
16 certify was partly designed to get at this view, and I think
17 in some cases it was well-founded, that the agencies were
18 going out to beneficiaries' homes and saying, would you like
19 home care and then sending the order over to the doc and
20 saying, sign this, the person wants it. Also the split
21 between Part A and Part B, moving home care around, some of
22 that was a gimmick to get it off the Part A trust fund.

1 There was, perhaps after the fact but at least
2 there was a policy rationale as well that you were dividing
3 it up between those beneficiaries who were using it after a
4 hospitalization and those who were the others. In either
5 case, I think this requirement of the physicians -- and the
6 clinicians here should answer this -- I think that had a
7 dramatic impact on the number of beneficiaries and maybe
8 even the type of beneficiaries who were getting it and the
9 kind of care they got.

10 Now all of this may now seem shortsighted and not
11 cost-effective and there may be people falling through the
12 cracks that we think should be getting home care, but I
13 think we need to remember that however ill thought out it
14 now seems, at the time I think people thought it was well-
15 intentioned.

16 MR. HACKBARTH: I think that the core issue here
17 is the ill-defined nature of what we're trying to buy. I
18 think there have been historically different points of view
19 within the Congress about what the benefit should be and
20 whether in fact we were trying to accomplish a change or not
21 by implementing a new payment system. I think there's some
22 fundamental disagreement that's never been sorted out.

1 But you take the combination of the new payment
2 system with fairly strong incentives to economize with an
3 ill-defined product and it's pretty predictable I think that
4 you're going to get changes in the product, because the
5 economic incentives will be so strong that they will
6 overwhelm the underlying patterns. Whereas if you're
7 dealing with an area of medicine where there are very
8 clearly defined standards as to what you need to provide,
9 the economic incentives may have a very different, much more
10 limited impact.

11 So I think one of our core issues -- and we've
12 made this observation as I recall, in past reports -- is
13 that we've got a vague notion and not uniform consensus
14 about what it is we're trying to buy here.

15 Then on top of that we have the issues that Bob
16 and Carol alluded to. Once you accepted that we're going to
17 have a PPS system, a prospective payment system, are we
18 fairly allocating the dollars we've got for different types
19 of patients and what are the consequences of failure to do
20 so? Then finally, of course, we have our standard issue
21 about the update factor, is enough money in the system?

22 So we're in a position where we're focusing on the

1 update factor, which is in some ways the little tail on this
2 great big dog. The policy question that that ultimately
3 raises is to what extent are we going to help these problems
4 that we've been cataloging by pumping more money into the
5 system? I'll leave it at that. In some cases the money
6 might get to providers who will do good things with it and
7 begin to address some of the problems we've identified. But
8 I think it's safe to say that a high percentage of the
9 dollars will not go there and will go just to the bottom
10 line of people who are providing a different sort of
11 product. I think that's the dilemma that we face.

12 We're not going to resolve the longer-term issues
13 obviously in the next month, but I think we ought to use
14 this report as an opportunity to again lay out that there's
15 a lot more going on here that needs to be examined than just
16 the update factor and the aggregate amount of money in the
17 pool. I'll leave it at that.

18 DR. STOWERS: I just think we'd be remiss, even if
19 we don't give an update, to go forward to Congress and not
20 talk about the maldistribution of dollars within this pool.
21 I know we did it before, but we have one set of
22 beneficiaries which it's very lucrative to take care and

1 another set of beneficiaries that it's very difficult to get
2 care for. It just seems like to me that ought to be brought
3 to their attention again that that needs to be addressed.
4 For us just to say, things are great in the industry,
5 there's no need for an update, I just would hate to send
6 that message to Congress.

7 MR. HACKBARTH: Refresh my recollection, we
8 certainly have anecdotal information about that. I don't
9 know if we've got actual systematic data on which types of
10 patients are getting poorly served or not getting adequate
11 access.

12 MS. CHENG: I've tried to put together a little
13 list here. I think realistically between now and January we
14 could -- we do have the OASIS on hand with our contractor at
15 OCS. We could ask them to look at 1999. They have 2000 and
16 2002. We could ask what kind of conditions were the
17 patients admitted trying to improve in those years, in terms
18 of has there been a change in the number of patients with
19 wounds that needed care over that time? Was there a change
20 in the number of patients who needed functional improvement
21 that had some kind of functional limitation? We could get a
22 trend of that over time to take a look at this question of

1 how have the needs of the patients been changing.

2 We could use OASIS. I don't think we can really
3 get at a good hospital readmit rate, but what we could do is
4 look at ER use and unplanned hospitalizations during the
5 episode. We could look at those three years and see if that
6 trend has changed over time to get a sense of the ER and the
7 hospital use of this population.

8 One of the things that I brought a couple of
9 months ago was based on the CAHPS fee-for-service survey.
10 We looked at the difference between the proportion of
11 beneficiaries who indicated they sought some kind of home
12 care and our estimate of the number of beneficiaries who got
13 some kind of home health care. In 2000 we found that 7.7
14 percent of beneficiaries sought some kind of home health
15 care and 7.5 percent did receive it. We could pull that
16 trend forward, I think, with the data we've got on hand to
17 look in 2001 and 2002 to see if the difference between
18 seekers and obtainers has changed.

19 MS. RAPHAEL: In your data here, in that survey
20 you had 25 percent of the people had some problem or great
21 problem in accessing care, and the 12 percent that had a
22 significant -- you thought the 12 percent that had a large

1 problem you thought was statistically significant actually.
2 So you have one out of four that had some problem or a great
3 problem, and I'd like to understand that better.

4 MS. CHENG: Okay.

5 MS. DePARLE: Also when you say sought home health
6 care, 7.7 percent, does that mean they had a doctor's order
7 to get home health care?

8 MS. CHENG: The question was worded, did you feel
9 or did a physician advise you to seek home care over the
10 past year.

11 DR. WAKEFIELD: If you can, is could you also take
12 a look at whether or not you could give us some sense of the
13 distribution of hospital-based home health agencies by urban
14 versus rural? You said that you think that they're pretty
15 much the same distribution.

16 MS. CHENG: Yes, that was another item on my list.
17 I'll see what I can bring you back of the hospital-based
18 margins. We haven't dealt directly with the caregiver
19 issue. I don't think I can bring too much data to bear on
20 the question. If you're interested in maybe a discussion of
21 the caregiver and how that's accounted for or not accounted
22 for in the PPS payment system I could bring that back as

1 well.

2 DR. STOWERS: Could you give us the different like
3 income or profit margin or whatever for different types of
4 patients?

5 MS. CHENG: For different types of patients?

6 DR. STOWERS: Like rehab after a total hip that's
7 gone home versus an acute episode of congestive heart
8 failure, that gets physical therapy and all of the rehab,
9 what that payment would be.

10 DR. MILLER: I think we want to be careful about
11 saying whether we can do that. Even if we have the cost and
12 payment ratios here it's a question of allocation. I think
13 the answer to your question is we can look and see what we
14 can do. I just don't know whether we're going to be able to
15 tell you for this HHRG or whatever, this is the profit
16 margin.

17 MS. CHENG: I was going to be more cautious than
18 you're being. I'm not sure we could pull that off.

19 DR. REISCHAUER: I'd be very careful about
20 promising anything definitive on hospital admission or
21 readmission rates simply because you can't just look at the
22 folks who have the home health care. What you want to look

1 at is everybody with this condition and what difference home
2 health makes. Then you have to control for the people who
3 don't have home health for that condition but have the
4 functional equivalent of a family that is doing some of this
5 themselves. As you know, it's horrendously complex and I
6 don't want some of the other commissioners to get an
7 expectation that you could actually come up with something
8 here and interpret it in the right direction.

9 Carol was looking at Table 1 and thinking that the
10 glass was half empty, and I was looking at it and thinking
11 it was half full and was going to say that we have to be
12 very delicate in how we describe the situation if the theme
13 of the first few pages here which is that supply seems to be
14 adequate. Things are okay. Those who want it seem on the
15 most part to get it. We have to draw on Glenn's remarks
16 which is the nebulous nature of this service. Many people
17 maybe don't know what it is that they could benefit from,
18 especially when you go from a change of the system like we
19 had in 1996 to what we have now. The people are different,
20 their expectations aren't to get all of this so they don't
21 look for it and they aren't unhappy. But they could benefit
22 maybe.

1 MR. HACKBARTH: Thank you, Sharon. We need to
2 move ahead now. Next up is hospitals.

3 MR. ASHBY: In this session we are going to use
4 our usual two-step process to develop update recommendations
5 for hospital inpatient and outpatient services for fiscal
6 year '05. But before I begin I wanted to take just a brief
7 moment to acknowledge that while you're going to hear from
8 Chantal and David and I on this project we actually had
9 several other people that contributed substantially here.
10 Tim Greene took the analytical lead on a very complex
11 modeling effort, Craig Lisk brought us the margins we're
12 going to look at, Jeff Stensland did a very useful
13 disaggregation of cost growth, Julian Pettengill helped
14 throughout, as he always does. We pulled in our post-acute
15 team to look at hospital-based services. We pulled in Dan
16 Zabinski to look at per-capita analysis. It was a cast of
17 thousands and we appreciate the efforts of all of them.

18 Now back to our previously scheduled slide. We
19 considered six factors in assessing payment adequacy, the
20 same save factors that we looked at in the other sectors.
21 We will proceed through them one by one in advance of our
22 draft recommendations.

1 Beginning with beneficiaries' access to care, we
2 examined two indicators, change in number of providers and
3 the per-capita service use of beneficiaries.

4 We found no indication that access to care has
5 deteriorated. The chart that we have here shows the number
6 of hospitals participating in Medicare. If you'd look first
7 at the white bars, or yellow on the screen, you see that 636
8 hospitals converted or opened as critical access hospitals
9 through 2002. Actually that number through October of this
10 year has risen to 835. Certainly that trend has done a
11 great deal to stabilize access to care in rural areas. Then
12 with the dark bars on the left we see that number of
13 hospitals ceasing participation other than through
14 conversion to CAH has dropped each year since 1999, and as
15 of 2002 you'll notice that the number closing is actually
16 equaled by the number opening.

17 Actually a moment first before we move to volume.
18 Our analysis of per-capita service use in 1999 and 2000 --
19 unfortunately 2000 is the latest that we have -- shows that
20 overall service usage is holding steady and that rural
21 beneficiaries continue to use services at roughly the same
22 rate as urban beneficiaries.

1 For volume growth we examined change in the number
2 of discharges and change in length of stay. A large drop in
3 volume might indicate that payments are inadequate, but in
4 fact we found that volume continues to increase. In the
5 first chart here we see that although discharge growth
6 dropped slightly in 2002, the annual rate is still about 3
7 percent for Medicare and about 2 percent across all payers.
8 The next chart shows the change in length of stay. You can
9 see that the decline in length of stay has slowed until in
10 2003 length of stay for both Medicare and all payers
11 declined by only 3/10ths of a percent, and that is the
12 smallest decline that we've seen since the late 1980s.

13 We have quality of care followed by access to
14 capital next and I wanted to turn the mic over to David for
15 those two.

16 MR. GLASS: Quality of care we see some mixed
17 results. We looked at some indicators developed by AHRQ and
18 that we applied to the Medicare population. From 1995 to
19 2002 we looked at an in-hospital mortality rates, and for
20 all eight of the indicators we looked at the rates analyzed
21 went down. If we looked at 30-day post-admission mortality
22 rates there was also improvement in six of the indicators.

1 Two of them moved up slightly.

2 Now what we did see was some deterioration in
3 rates of patients adverse events, or these are called the
4 patient safety indicators. We looked at 13 of those and
5 nine of those 13 rates of adverse events went up over the
6 period from 1995 to 2002. We'll discuss those findings in
7 detail tomorrow.

8 By another measure, the CMS process measures
9 showed improvement. CMS, through its quality improvement
10 organizations, tracked 22 process indicators and there was
11 improvement in 20 of the 22 for the period 1989-'99 to 2000-
12 2001. You have to use two years of data for those because
13 they're taken from medical records based measures. So
14 quality of care is somewhat mixed.

15 Access to capital continues adequate. As the
16 slide shows, spending construction is strong, more expansion
17 planned, 80 percent of the non-profits are planning on
18 expanding, debt issuance is increasing. Access varies by
19 financial condition. Poorer performing hospitals are going
20 to face more of a challenge, yet they still seem to be able
21 to obtain capital, though they may have to pay more for it.
22 There has also been use of some less traditional financing

1 such as selling physician office buildings and things like
2 that to raise capital.

3 We'd also like to note that hospitals in systems,
4 which are over half of the hospitals, have better access to
5 capital than the stand-alone hospitals in general. So
6 access to capital seems to be good.

7 MR. ASHBY: Turning to the appropriateness of our
8 cost base, we found unusually high cost growth in both 2001
9 and 2002. We'll talk in a minute about some of the possible
10 reasons for that high cost growth, but the bottom line is
11 that we find no basis for concluding whether the growth was
12 unnecessarily high, but this obviously is something that
13 we're going to want to watch closely over the next year.

14 Our chart here shows that the rate of growth in
15 cost per discharge has grown rather dramatically from 0.1
16 percent in 1997, and that was at the period of time when
17 length of stay was falling rapidly, to 6.6 percent in 2001.
18 Again that's a level that we haven't seen since the 1980s.
19 For 2002, our preliminary value, based on 60 percent
20 reporting, is even higher; 8.1 percent increase in cost per
21 case. But for the 40 percent of late reporters that are yet
22 to come in for 2002 we may have somewhat slower cost growth.

1 We'll talk about the reasons for that in just a moment.

2 To better understand these large cost increases we
3 disaggregated the extra increment of cost growth in 2001-
4 2002 relative to the year. We found that three factors,
5 labor costs, malpractice costs, and capital costs were
6 responsible for essentially all of the additional growth.
7 Those three factors are shown in their order of importance
8 here.

9 Starting with growth in labor costs, this was a
10 key factor in both 2001 and 2002. Again, in the order of
11 importance, that is attributable to greater growth in number
12 of employees, greater growth in wages and benefits, and
13 increased use of contract labor. Independent analysis by
14 Peter Burhouse and others strongly suggest that much of the
15 increase in employees, employees and contract labor
16 actually, can be linked specifically to nurses.

17 They found, using the current population survey,
18 that the number of FTE RNs employed by hospitals increase 7
19 percent in 2002 alone. The way that we define time periods,
20 that 7 percent actually affects both our 2001 and our 2002
21 data. Burhouse also suggests that the crisis in nurse
22 employment may already be ebbing, at least temporarily.

1 There are long-term structural factors but for the short
2 term the problem seems to be ebbing.

3 I would also note that benefits increased even
4 faster than wages, and that maybe due, at least in part, to
5 hospitals being required to add funds to their retirement
6 reserves as the value of their stock holdings fell. But
7 with the stock market improving that should become less of a
8 factor. Then also hospitals, like a lot of other
9 organizations, have seen their employee benefit costs,
10 health benefit costs affected by double-digit premium
11 increases. Wouldn't want to hazard a guess on how long that
12 phenomenon will go on but it was relevant here.

13 Malpractice costs. These costs increased a
14 startling 35 percent in 2002, although malpractice is
15 actually a very small share of hospital costs. But
16 malpractice premiums are cyclical and we would not expect
17 that level of increase to continue.

18 Capital costs. These also surged primarily in
19 2002. It's obviously linked to the renovation and
20 construction boom that David talked about a moment ago.
21 Whether all of the investment that we've been seeing is
22 really necessary is an open question. It's something we

1 really haven't attempted to analyze, but it certainly is a
2 relevant question. We would also point out that capital
3 payments are made prospectively, like operating payments.
4 They are made at a steady rate, so we would really expect
5 the profit margin on capital payments to be somewhat lower
6 at the front end of the capital cycle, and we would
7 correspondingly see higher capital profits years down the
8 line.

9 Some have suggested that the higher cost growth,
10 particularly the higher labor costs, are essentially making
11 up for the extreme cost pressure the hospitals were under in
12 the last half of the 1990s. Certainly we can cite the fact
13 that smaller length of stay declines have been a factor.

14 But on the other hand, others have suggested that
15 the willingness of private insurers to grant much larger
16 payment increases in the early 2000's may have fueled
17 excessive cost growth. Yet another possibility is that the
18 measured growth in inpatient cost per case -- we're
19 essentially talking about inpatient here -- may be
20 artificially inflated in recent years by hospitals halting
21 their past practice of allocating as much cost as they could
22 to the outpatient and post-acute care sectors in the cost

1 report since with PPS in those sectors there's really no
2 longer any incentive to do so. We don't have any way at the
3 moment of confirming how big a factor that might be.

4 Considering all of these factors, we find it quite
5 difficult to determine the appropriateness of cost growth
6 that's more than twice the increase in the hospital
7 marketbasket, or to determine how quickly the industry can
8 return to a more normal pattern of cost growth. But one
9 indication that the unusually high cost growth may already
10 be abating is provided by hospital wage and benefit data
11 from the Bureau of Labor Statistics. Percentages you see in
12 the graph here are four-quarter averages ending in the
13 particular quarter noted. The peak increases of about 5.5
14 percent midway through 2002 had dropped to almost 4 percent
15 by the end of fiscal 2003. That's when our actual
16 measurement leaves off. The projection is that it will
17 decline somewhat more through 2004.

18 Turning to our margins, this graph shows the trend
19 in the overall Medicare margin, which we use to assess
20 payment adequacy, and also the Medicare inpatient margin
21 which provides the only available tool that we have to
22 document the upward trend in margins during the 1990s. In

1 2001, the overall Medicare margin fell by 8/10ths of a point
2 to 4.3 percent. The inpatient margin dropped a bit more,
3 but that decline was offset by increases in the outpatient
4 and hospital-based home health sectors.

5 The next slide shows our estimate of the overall
6 Medicare margin for 2002 and our projection to 2004. The
7 2002 value of 3.2 percent shows a drop of about one point
8 from 2001, obviously reflecting the high rate of inpatient
9 cost growth that we have been discussing here. Our
10 projection accounts for a number of policy changes that
11 occurred between 2002 and 2004, and then also a number of
12 policy changes that the conference agreement has scheduled
13 to go into effect in 2004 or 2005.

14 So the 2.8 percent figure that we see here
15 represents what the margin would have been, what we think it
16 would be in 2004 if 2005 policy had been in effect. I
17 really need to emphasize though that our projection is
18 preliminary. This has been a rather difficult analysis. We
19 have modeled the effect of 23 different policy changes in
20 coming up with this one number, and that's not even counting
21 updates which are essentially a gimme in the modeling world.
22 So we have a bit of refinement yet to go.

1 But we will have a final number in January. We
2 don't anticipate that the final number will be much
3 different than what we're looking at here. Then we're also
4 planning to present result of this analysis by hospital
5 group. That will bring some interesting results we think.
6 Among other things, we expect this to document a substantial
7 narrowing of the margins between urban and rural hospitals.
8 In fact we may even be reporting that the aggregate rural
9 margin may exceed the aggregate urban margin when all these
10 provisions are in effect.

11 Turning to first our inpatient update
12 recommendation, and that will be followed by the update for
13 outpatient. A little bit of context first. The current law
14 increase is marketbasket even, with now a 4/10ths of a
15 percent reduction for any hospital that does not first
16 quality to CMS. CBO reports spending for the inpatient
17 sector in 2003 of \$94.5 billion.

18 Four primary factors govern our draft update
19 recommendation. First is that we conclude that payments are
20 adequate through fiscal year 2004. Although our 2.8 percent
21 current margin is about a point lower than we've reported
22 out the last couple of years, the other factors that we

1 looked at in our update framework don't provide any evidence
2 of inadequate payments. Also, the conference agreement has
3 removed the budget neutrality constraint from our inpatient
4 new technology pass-through payments, and also has
5 liberalized the criteria for technologies to qualify for the
6 pass-through.

7 Then our second factor is the projected
8 marketbasket increase. That is 3.2 percent. Third, we have
9 our productivity factor of 0.9 percent. Lastly, we have our
10 allowance for cost-increasing technologies of 0.5 percent.
11 We'd like to note here that in future years we may find it
12 appropriate to eliminate this technology allowance if
13 spending for the new tech pass-through payments increases
14 substantially. But we really don't know how that's going to
15 play out. It depends somewhat on how CMS administers the
16 conference agreement provision which has several little
17 details to it, and also the number and the type of
18 applications that come through. So we felt that for this
19 year it's appropriate to leave the technology allowance in
20 place while we monitor the implementation of the new
21 provision in the coming year.

22 So marketbasket less 0.9 percent plus 0.5 percent

1 produces an update of marketbasket minus 0.4 percent as
2 reflected in our draft recommendation statement here.
3 However, one last point, and that is that we can't be sure
4 about cost growth even for the remainder of the current
5 fiscal year -- we're only two months into fiscal year -- for
6 next year, as we've been talking about here. But the
7 recommendation is for only one year, so we'll have an
8 opportunity to revisit this in another year, and in the
9 meantime to monitor the pattern of cost increases as well as
10 the implementation of this substantial number of complex
11 provisions that will go in from the conference agreement in
12 the next year.

13 This recommendation would increase spending less
14 than under current law, and given our analysis of the
15 factors today we don't expect any major implications for
16 beneficiaries or providers.

17 So at this point we'd like to bring Chantal on to
18 talk about the outpatient update recommendation.

19 DR. WORZALA: Good afternoon. We'll be making an
20 update recommendation for calendar year 2005. Under current
21 law the update would be marketbasket, and the outpatient PPS
22 update was not affected by the current legislation. The

1 Office of the Actuary estimates that spending under the
2 outpatient PPS is \$28.6 billion in 2003, about 38 percent of
3 that spending coming from the beneficiaries. The outpatient
4 PPS was implemented in August of 2010 and spending has
5 increased dramatically since then, rising 9.5 percent between
6 2001 and 2002, and an estimated 7.5 percent from 2002 to
7 2003. Growth rates going forward are projected to be 8
8 percent or so.

9 As Jack discussed, we consider payment adequacy
10 for the hospital as a whole, mostly due to issues of cost
11 allocations across service lines. Jack went through the
12 major elements of payment adequacy from the framework. I
13 just want to highlight a couple of items specific to
14 outpatient services, including the share of hospitals
15 providing outpatient services, increases in volume of
16 services, and a quick look at the outpatient margin trend.

17 First, we've seen an increase over the past decade
18 in the share of hospitals participating in the program that
19 provide outpatient services. We see no change between 2001
20 and 2002. So the share of hospitals providing outpatient
21 services and emergency services is high; 94 percent and 93
22 percent, respectively, and 84 percent of hospitals provided

1 outpatient surgery in 2001 and 2002, up from 79 percent in
2 1991.

3 In the looking at the volume of services under the
4 outpatient PPS, there's been a very quick increase of 15
5 percent in the volume of services provided per fee-for-
6 service enrollee. I want to note that this is an increase
7 in the units of service provided, so not in the number of
8 visits. There are a number of explanations for that very
9 high level of growth, some of which are really more data and
10 classification issues. But there is also an underlying real
11 trend in volume growth. Anecdotal evidence and examination
12 of the claims suggests that hospitals improved their coding
13 between these years so they're coding more services in 2002
14 than 2001, even though they may be providing the same
15 services. So units of drugs and things like that are more
16 accurately coded, leading to the suggestion of greater
17 increase than there might really be.

18 In addition, the payment system underwent changes
19 in service definition, unbundling some things such as some
20 drugs and blood products. This would also lead to an
21 increase in units because we're now counting those as
22 separate units instead of part of a bundle. But there is at

1 base some real volume growth. We know that in the payments
2 increased 9.5 percent while the update was only 2.3 percent
3 in 2002.

4 This is a preliminary look at the outpatient
5 margins. We will be coming back with confirmation of these
6 numbers in January as well as some of the distributions by
7 hospital group. These are margins for all outpatient
8 services, although for most hospitals the payments on the
9 cost reports for 2001 and 2002 are 98 percent from the
10 outpatient PPS because payments for non-PPS fee schedule
11 items are reported on different worksheets than those we
12 took our margin payments from.

13 We see you here a substantial improvement in
14 margins that coincides with the implementation of the
15 outpatient PPS, moving from negative 12.2 in 2002 to
16 negative 6.2 in 2001 and then a drop from 2001 to 2002 to
17 negative 6.7. The 2002 number comes from a sample of 60
18 percent of the hospitals. For the outpatient margins we did
19 impute values for hospitals where we had a 2001 cost report
20 and not a 2002 cost report.

21 Some explanation for the trend in the cost
22 reports. There may, as Jack said, be some shift in the cost

1 allocation back towards the inpatient and away from
2 outpatient. But we do also see payments increasing quickly.
3 According to the Office of the Actuary there was a 16
4 percent increase from 2000 to 2001 for all outpatient
5 services exclusive of lab, and then 9.5 percent from 2001-
6 2002, 7.5 from 2002 to 2003. 2001 was also a period where
7 the pass-through payments were not capped under the
8 outpatient PPS.

9 This is also a period where the transitional
10 corridor payments were being made. CMS had estimated that
11 the transitional corridors would raise payments by 4.4
12 percent across all hospitals although we're seeing -- and
13 I'll talk about this again a little later -- more like 2.3
14 percent of payments coming from those transitional
15 corridors. But again, that's new money flowing into the
16 outpatient system that would lead to improvements in the
17 margin. Hospitals may also have been looking to control
18 their outpatient costs in response to uncertainty over how
19 this new payment system would work.

20 So that was a little bit of amplification of the
21 payment adequacy specific to the outpatient PPS and now
22 we'll turn to the update factors. First, of course, looking

1 at our best estimate of per-unit change in input prices.
2 That's the hospital marketbasket increase. The latest
3 estimate for 2005 is 3.2 percent.

4 Then when we look at the impact of scientific and
5 technological change we see that there are already
6 mechanisms in place to account for the cost of new
7 technology in the outpatient PPS. We have the new
8 technology APCs which pay for completely new services, and
9 the services are placed in a new tech APC based only on
10 their expected costs. We've seen a growth in the number of
11 HCPC codes that fall into those new tech APCs from 75
12 services in 2003 to 88 services in 2004. There are an
13 additional four applications under consideration at CMS with
14 applications coming in and being considered on a quarterly
15 basis.

16 Again, this provision generates a payment for each
17 service and there's no budget neutrality constraint there so
18 it's really increased expenditures. Our analysis of the
19 claims show that in 2001 about 1 percent of payments went to
20 the new technology APCs and in 2002 that rose to 1.5
21 percent.

22 The second technology provision are the pass-

1 through payments. Here we're really making an incremental
2 payment for something that is in input to an existing
3 service. This is budget neutral and the bulk of the pass-
4 through payments have moved into the base payment system and
5 now we're really getting new technologies flowing through
6 this pipeline with a much smaller number. In 2004, there
7 are nine device categories and 22 drugs with pass-through
8 status. There are additional applications being received
9 and looked at on a quarterly basis.

10 One last provision that will affect new technology
11 and add additional money to the payment system is a
12 provision in current legislation that sets a floor under the
13 payment rates for drugs that is tied to AWP. This is not a
14 budget neutral provision and CBO put an increment of \$700
15 million between 2004 and 2005.

16 So for these three reasons we don't see the need
17 for any kind of allowance for S&TA in the update.

18 Finally, we look at productivity. Again, the 10-
19 year moving average of multifactor productivity in the
20 economy as a whole is 0.9 percent. This is somewhat of an
21 expectation that really ties productivity in this sector to
22 the productivity of the people who fund the program.

1 Given these factors we propose the following draft
2 recommendation for your consideration. The Congress should
3 increase payments for the outpatient PPS by the increase in
4 the hospital marketbasket less 0.9 percent for calendar year
5 2005. This recommendation would lead to a smaller increase
6 in spending than current law, and we anticipate no major
7 implications for beneficiaries and providers from this
8 recommendation.

9 MR. HACKBARTH: So we still need to talk about the
10 outlier issue for the outpatient. But before we turn to
11 that why don't we address the update factors for inpatient
12 and outpatient? Any questions or comments?

13 I have one. From my perspective the information,
14 the breakdown of margins by type of hospital is going to be
15 even more important than usual. The reason I say that is
16 from my perspective one might feel very different about a
17 2.8 percent margin if there's a tight distribution around
18 the average than -- in fact you might feel better about a
19 2.8 percent margin with a tight distribution around that
20 average than you felt about a 3.9 percent margin with big,
21 fat tails, including a lot of hospitals losing money.

22 I think directionally at least, one of the things

1 that happened with the reform legislation is that the number
2 of hospitals losing money ought to be significantly reduced,
3 certainly among the rural hospitals which were
4 disproportionally in that group. I think that's consistent
5 with what you said, Jack, about your thinking that the
6 average margin for rural hospitals increased significantly.
7 So I think it's not just the average that we need to focus
8 on but also the distribution around the average, so I look
9 forward to seeing those data.

10 DR. WOLTER: I guess I'll just express again, one
11 of the concerns I have is in terms of how we look at our
12 margin analysis sector by sector. On the one hand we say
13 that we want to look at each sector and try to look at the
14 information and make an update recommendation. On the other
15 hand, we say cost allocation issues prevent us from doing
16 that and, therefore, we should look at an overall Medicare
17 margin. Today we heard that maybe the cost allocation
18 decisions are being made in a reverse direction, so I don't
19 know what we should do with that suggestion in terms of the
20 outpatient recommendation versus the inpatient
21 recommendation.

22 I know we can't fix this in the short run, but I

1 wonder as a commission if we should have a goal of moving to
2 the day when we think the data actually helps us to make the
3 decisions sector by sector, because it is difficult. It
4 troubles me actually to find ourselves making these
5 decisions in such a speculative manner.

6 The other thing I'm wondering about is if there
7 was a year where the data would suggest that a full
8 marketbasket on inpatient might be indicated this certainly
9 would be it, from what I've just seen in terms of the
10 increase in costs and the margins going down. I'm concerned
11 about that, especially when you pair it with what still
12 looks like a negative 6-plus percent margin on outpatient
13 side.

14 Related to that, I would say that it was
15 interesting what happened in recent legislation in that the
16 full marketbasket update was at least paired with some
17 reporting of quality data, which again as a commission we've
18 said that we want to support. So I'm wondering if there's
19 anything linking to that that we would want to consider in
20 the terms of quality reporting on the inpatient side.

21 Those would be the issues I would raise in terms
22 of this information.

1 MR. HACKBARTH: Do you want to respond to those?

2 MR. ASHBY: A couple of things I wanted to respond
3 to there. First on the allocation issue. We can at least
4 remind ourselves that our rather old data that we do have on
5 what allocation is doing to the inpatient versus the
6 outpatient margin suggests that the outpatient margin may
7 have been understated by as much 15 percentage points. So
8 while that's not a very precise measurement, I think there's
9 really very little doubt that the real outpatient margin is
10 now in positive territory with the minus 6 that we see on
11 paper. There's still a lot of variation around it that we
12 don't understand very well but I think we can at least say
13 that much with confidence.

14 MR. HACKBARTH: Is it possible, Jack, as opposed
15 to speculate about that, to systematically try to get a
16 handle on it? I think that's what Nick is asking, can we
17 advance beyond this point to where we'd feel much more
18 confident that we know?

19 MR. ASHBY: We have a study underway that is
20 designed to shed light on this issue. We will look at the
21 allocation of cost that the hospital cost accounting systems
22 can provide for us, and then restate our margins and see how

1 they come out. Now again, there's no perfect system here.
2 We can never say the correct margin is whatever, but that
3 will shed some light on the extent to which this allocation
4 problem still exists, whether there's been any turnaround in
5 the allocation. That will come up hopefully in the spring,
6 late spring.

7 DR. MILLER: Could I just have at a couple things?
8 I think we shouldn't be as strong as the statement of, we're
9 clear at this point that the outpatient margin should be
10 positive at this point. I think we don't know. I think it
11 is a frustrating problem, and it's no fun for us to have to
12 repeatedly have to come in front of the Commission with the
13 data sources that we have and present what we have.

14 The other thing -- and I hate to be so negative
15 here, but the other thing about this study that we're
16 referring to is we'll have it if hospital systems choose to
17 participate in it. If they don't, then it's not clear to me
18 that we will have it. So we need to be clear when we make
19 these statements, it depends on the participation of
20 hospitals and their willingness to give us cost accounting
21 data to do this. So it's a bit tough.

22 One last thing I'll say, and you've made this

1 point in the last meeting and we are trying to take it
2 seriously and we are getting something of a push in this
3 direction. There's a couple of provisions -- they're not
4 quite on point to your concern here -- of looking at other
5 data sources that are included in the bill that we have to
6 do now as mandated studies, and it can give us a push in
7 this direction. Because I think in the last meeting you
8 said, at least in principle if we could articulate what kind
9 of information at least and then, are there other sources?
10 We will try to travel down this road. I just don't want to
11 over-promise on this cost allocation study because if the
12 hospitals don't step up we will have nothing.

13 DR. WOLTER: I think philosophically, if our
14 framework is to cover the cost of an efficient provider
15 sector by sector, that might lead to an agenda where we try
16 to get the data sets that allow us to do that. Now it may
17 not be possible, but it is a little bit frustrating when we
18 are dealing with this blend.

19 Then back on the allocation or the outpatient
20 side. This is just anecdotal so it's only worth that. But
21 in visiting with my CFO and a number of others I get a
22 fairly strong message that if that was occurring it

1 certainly hasn't been occurring in recent years, and that
2 there may be issues around how hospitals allocate having to
3 do with their fixed costs or their square footage or
4 whatever, but that this really isn't an activity that they
5 feel is very prominent at the moment, for whatever that's
6 worth.

7 DR. REISCHAUER: Just a couple of questions about
8 the charts. I wasn't clear, Chantal, if you gave us a
9 reason why the margins seemed to plateau at minus 6 from
10 2001 to 2002. You'd be a lot more comfortable about the
11 story that we've been telling if the pattern was minus 12,
12 minus 8, minus 6, going in a direction and hospitals were
13 slowly adjusting to the real world here. But when it levels
14 off and then Jack says, when you put his set of glasses on
15 he sees plus.

16 DR. WORZALA: I can talk a little bit about the
17 change from 2001 to 2002. One thing is that the 2002
18 numbers are from a sample.

19 DR. REISCHAUER: Are incomplete.

20 DR. WORZALA: But in addition there were policy
21 changes between 2001 and 2002, so the transitional corridor
22 marginal payment percent was declining from 2001 to 2002.

1 In addition, 2001 is when a lot of excess dollars flowed
2 through the pass-through mechanism and that did not happen
3 in 2002. So there are policy reasons for that.

4 DR. REISCHAUER: So just to hold their own they
5 would have had to have done -- something else would have had
6 to have been going on.

7 DR. WORZALA: Right. In addition, as Jack
8 discussed, we did see higher cost growth. He showed the
9 cost growth per case, but these are really the same inputs
10 whether it's inpatient or outpatient. We unfortunately
11 don't have a unit measure for outpatient services on the
12 cost report so we can't do an analogous assessment of cost
13 growth per outpatient encounter or service or something like
14 that. But the nurses are the same -- you're paying them the
15 same whether it's inpatient or outpatient. A lot of the
16 ancillary departments, it's the same inpatient and
17 outpatient, so that cost growth would affect the outpatient
18 as well as the inpatient.

19 DR. REISCHAUER: On that cost growth, is there any
20 way to ferret out the increasing complexity of the average
21 Medicare discharge? If the simpler things are going into
22 outpatient over time and what remains is a resource-

1 intensive procedures with higher costs.

2 MR. ASHBY: Right. We have two potential
3 measures, one is our normal case mix index across DRGs. It,
4 I believe, is holding fairly steady. We could measure it
5 with an APR-DRG system which would begin to pick up severity
6 of illness, and we have not done that recently and I really
7 can't comment. But we have not seen with the tool that we
8 do have any significant increase.

9 However, I even have to caveat that by saying, you
10 never quite know what the case-mix index, the degree to
11 which it is measuring real resource changes or whether we're
12 picking up coding changes. In recent years the coding
13 emphasis has been downward, if anything, in response to all
14 the inspection that's been going on and the like. So we saw
15 a couple of years of actual declines in the case-mix index
16 but we suspect --

17 DR. REISCHAUER: That was a couple years ago.

18 MR. ASHBY: Yes, that was a couple years back.
19 Now it's stabilized and that's the best we know.

20 MR. MULLER: As we make the projection of the '04
21 margins, I remember the last couple years the industry
22 groups would say that the costs are rising much more than

1 the marketbasket we're putting in. So for example, the 6.6
2 you showed today and I think you said it might have been 8.2
3 percent in '02, so if in fact the costs in '02 or '03 were
4 really going at the 6, 8 percent range, is that what you're
5 doing -- are you assuming that's what you're projecting the
6 costs forward from the '01 based at 6 and 8 percent or are
7 you projecting it forward at the 3 percent range?

8 MR. ASHBY: We began with a projection for '02 and
9 we did pull in that full cost increase that we talked about
10 here. We used a factor that's a sliver lower than the 8.1
11 because some of our reporters are actually pushing into '02.
12 But we think that that reflects the full cost increases that
13 were actually happening.

14 Then for '03 and '04 we do have somewhat of a
15 standard there. We projected forward at marketbasket minus
16 just half of the productivity increase. But that reflected
17 a look at the cost pressures and evidence that some of the
18 cost pressures are beginning to subside. We have evidence
19 in the literature that the big push to hire nurses and other
20 technical personnel is really abating. We saw the graph
21 there that showed the wage increases rather abating. And on
22 capital, as we said, we view that a little differently. We

1 probably will consider to have sizable cost increases as we
2 measure capital expenses, but given the capital cycle it's
3 not clear that that's something that we should be responding
4 to. This is something that will have a cycle to it. We're
5 in the upward part of the cycle, and we will later be in the
6 downward part of the cycle.

7 So looking at all those things together it seems
8 that a return to cost growth that's in the neighborhood of
9 marketbasket seemed like a realistic possibility. But as we
10 said, we don't really know. I think the best that we can do
11 is look at it today and perhaps return a year from now and
12 season the extent to which this is bearing out.

13 MR. MULLER: Then if it were a couple sixes again
14 in '03 and '04 versus threes that would be a cumulative
15 another 5, 6 percent which would take the margin not in the
16 projected 2.8 but to negative territory. I'm just doing the
17 arithmetic again, just Glenn's cautions.

18 MR. ASHBY: Indeed. After a number of years of
19 that level of cost increase you'd really want to start to
20 take a look at why we're seeing that kind of cost --

21 MR. MULLER: There's a couple things going on
22 that, obviously hitting all of the American economy that's

1 been -- first of all, a lot of these hospitals are employers
2 so they do pay health insurance premiums for their folks at
3 a 10, 12, 14 percent range. Maybe not the marginal costs
4 but there have been major increases to everybody in terms of
5 pension costs the last few years. There have been major
6 worker's comp increases and so forth. So when you look at
7 the staffing cost, those things really start -- and maybe
8 the nursing costs have slowed down but some of these other
9 costs that are affecting all employers, not just hospitals.

10 So in fact I would not be surprised at all to see
11 that in fact it has been another couple years of 5, 6
12 percent, and therefore the likelihood that when we do our
13 updates -- when we show the data two years from now --
14 because really we were sitting here two years ago saying
15 it's going to be say and the industry was coming in and
16 saying it was six, and I think they were a little closer to
17 the data. My guess is that's true again now. So that
18 probably when we're sitting here two years from now we'll
19 find that the costs went up 5, 6 percent each of the last
20 two years and that the margins are not 2.8 but I think the
21 margins probably are going to be less than 1 percent.

22 So when we look at adequacy, in some ways that

1 assumption that it's a 3 percent cost increase so dwarfs
2 everything else we discuss here, so by making that
3 assumption, is that assumption is really way off, we can be
4 sitting here with an illusion that it's gone from 3 to 8,
5 but it may have gone from 3-something to 0.5 very quickly
6 based on some very really evidence as to how much the cost
7 have gone up the last few years.

8 I understand that if the industry is not
9 cooperating as fully as you want in terms of getting this
10 cost data coming forth, then it's hard to -- other than
11 using your marketbasket. But my sense is, in looking at it
12 that we're going to be -- this 6 percent was quite
13 predictable based on what people told us two years ago and
14 it's going to be 5 to 6 percent again for '02 and '03 is
15 pretty clear to me. So we can just put our projections down
16 and see where we are two years from now but it's not going
17 to be 3 percent for those two years that just passed.

18 MS. BURKE: I have two questions that I'm trying
19 to understand. The first is, in the document on page 6 we
20 reference the number and in fact reflect the tremendous
21 increase in critical access hospitals from 375 to 835 in
22 October of '03. The legislation as I understand it further

1 expands the definition and increases the bed size. So I
2 would assume ultimately in the report we will speculate to
3 some degree on how large this group is likely to become.

4 I wonder at some point, Glenn, over time if we
5 ought not look at that. You're increasingly, again, get a
6 larger and larger percentage of the hospitals that are
7 outside of the PPS system. Admittedly relatively small,
8 admittedly compared to some a relatively small impact. But
9 nonetheless, that whole concept of moving large percentages
10 -- I mean, we'll have a suspect somewhere in excess of 1,000
11 hospitals that will be outside the PPS. At some point that
12 has to have some impact on how we begin to look at this
13 system. I wonder at what point we should comment on that,
14 and certainly in the numbers but also reflect on perhaps
15 this is something that we ought to look at over time as we
16 go forward.

17 The second question that I have, in the
18 recommendation for the update for hospitals, going back to
19 that, you recommend marketbasket minus 0.4. In the
20 legislation as I understand it, they link a portion of the
21 update to the willingness and the ability of the hospitals
22 to submit quality data. Given what we now know and is

1 reflected in this document with respect to the increase in
2 adverse events that occur in hospitals, some of that may be
3 a function of reporting, better reporting. One wonders if
4 there isn't a bit of that. But I wondered why we didn't
5 pick up, or should we in fact pick up the linkage, begin to
6 tie some kind of willingness or participation in the quality
7 provisions as they relate to how we reimburse.

8 We have suggested in other aspects of our prior
9 reports the desire, and we do it here around dialysis and a
10 number of other areas, to begin to link, as we can, the
11 legitimacy of a payment to a quality outcome. But this in
12 fact is a data issue. That is, some kind of linkage to the
13 hospital's willingness to report, and whether that isn't
14 something we ought to think about as well. In this case we
15 did a minus 0.4. In the case of the legislation as I
16 understand it, it includes a 0.4 if in fact they are willing
17 and then it minuses a 0.4 if they are unwilling to submit
18 the information. I wonder if we had thought about that or
19 is that --

20 MR. ASHBY: Actually the way the legislation reads
21 is that it gives the actual update as marketbasket and then
22 says they will be penalized 0.4 off if they don't provide

1 the data. That same feature could be attached to our
2 recommendation.

3 MR. HACKBARTH: Let's have some discussion about
4 that. That was also one of Nick's points.

5 My personal initial reaction was, if assessing
6 processing quality is important, as I think it is -- I think
7 it's vital -- why is it optional even with an incentive?
8 Why isn't this a condition of participation in the program?
9 That was my initial reaction.

10 Then the second one was, if we say for hospitals
11 we're going to pay in some fashion for the data, does the
12 same hold true for every other class of providers? For the
13 combination of those two reasons I personally wasn't
14 confident that this was a good precedent to set.

15 MS. BURKE: If I could respond. I recall, and
16 Nancy-Ann will have to correct me -- we have in the past
17 explicitly paid for certain kinds of data. We did it in
18 Medicaid. We've done it in other places where we set a bar
19 and say, we want you to comply with whatever it is,
20 administrative flex -- whatever it happens to be. And we
21 have been willing to incentivize people to move in that
22 direction.

1 In this case, you're right, a condition of
2 participation ought to suggest that they ought to do
3 whatever it is that they ought to do. The complexity of the
4 data collection and analysis -- I mean, we have added over
5 time increasing burden in terms of what we are expecting
6 facilities to produce, and this is certainly true at smaller
7 units as well. The capacity of a hospital to do it, or any
8 kind of organized system is far greater than it is at
9 smaller units. Physicians' offices, we've admitted we have
10 an enormously difficult time gathering that information and
11 analyzing it on a per-unit basis. Organized systems could
12 increasingly begin to produce it. The hospital though is
13 the most obvious because it has the greatest demand in terms
14 of what it is we expect of them today.

15 I agree with you, over time it ought to go in the
16 direction where it is what we need, it is expected, do it.
17 But I wonder, given where we are today, given that we've
18 seen clear indication of an increase in adverse events,
19 whether or not we ought to put an emphasis on it in the
20 short term and then move towards it in the long term and
21 maybe say that.

22 I don't disagree with where you want to get. I

1 just wonder if in the interim we ought not create some kind
2 of strong message that quality increasingly is important and
3 we're willing to try and help you produce that. And maybe
4 over time we do it with the other facilities and the other
5 providers as well.

6 DR. WOLTER: Just another point on that, because I
7 agree with that and I think a second and third step,
8 whenever it comes around, conditions of participation would
9 be a great place to get to. As I understand what is going
10 to be required in terms of tying in the legislation that
11 payment to reporting it, it's data, but it's specifically
12 reporting of measures being taken, process measures that
13 have been shown to improve quality of care. So it really is
14 linking what's being reported to activities which have been
15 shown in the literature to improve quality. There's
16 potentially some value in that in these early stages of
17 trying to link payment to quality.

18 MR. ASHBY: Just one brief comment of the CAH
19 issue. While I think we all believe we could easily be
20 looking at 1,000 CAHs a year or two down the line, we also
21 have to remember though that the equation has changed here.
22 The payments are much more attractive now for small rural

1 hospitals under the provisions of the bill than they were,
2 so I think there will be a lot of rethinking of the right
3 decision here by some CEOs.

4 DR. WAKEFIELD: I was going to ask you that, Jack,
5 whether or not that wasn't a possibility, that there may
6 well be hospitals that are going to stay put because of
7 those new provisions making that automatically default to a
8 CAH not the better financial option.

9 MR. HACKBARTH: As I recall, that was basically
10 the stance that we took in our rural report, was rather than
11 have more and more hospitals opt out of PPS, let's fix PPS
12 so it's fairer to rural hospitals and make it a viable
13 opportunity.

14 MS. BURKE: Jack, you're absolutely right and I
15 wonder if that's part of what we ought to look at in terms
16 of what will happen. But you still have a large -- I mean,
17 there is still proportionally a large number who have
18 already, query whether or not more will because of the
19 expanded definition or whether or not these payment
20 adjustments will in fact satisfy what those needs are. But
21 you have states -- I don't know if this is still true of
22 Kansas, near and dear to my heart, but there was a point in

1 time when Kansas had 50 percent of its hospitals had fewer
2 than 50 beds. You had geographically huge chunks that could
3 move into these systems.

4 Now this may fix it. It may do exactly what has
5 been proposed. But it seems to be we ought to be watching
6 that to see whether or not it achieves what it intended to
7 achieve, which is to equalize the system.

8 MR. ASHBY: Absolutely. We have a report coming
9 up on the rural provisions and I think CAH as part of that
10 is absolutely appropriate.

11 MR. HACKBARTH: Other comments on the paying for
12 data issue?

13 DR. STOWERS: I was just going to back to what
14 Nick said. I just don't think there's anything wrong at all
15 with the Commission confirming the fact that it's okay to
16 pay for data and to recognize the fact that data cost money
17 to collect and that it's worth paying a little bit of money
18 for that. And for the technology and medical record systems
19 and so forth is a recognized expense in the hospitals. This
20 quality is going to cost some money and that Congress is
21 going to have to step up and help pay for it.

22 MS. DePARLE: If we're going to pay for that,

1 could we pay for quicker cost report or something that would
2 give us -- seriously. That's been one of our big bones of
3 contention is that the data that we use is always so lagged.

4 MR. HACKBARTH: I don't know how much of that is a
5 hospital issue as opposed to a CMS issue.

6 MS. DePARLE: Yes, an intermediaries.

7 MR. HACKBARTH: Of course we could pay them for
8 more data too.

9 Other comments on the data and payment issue?

10 Okay. Any comments on anything related to
11 hospitals, inpatient or outpatient?

12 Hearing none, do we need to do the outlier thing
13 now? Is that the next up?

14 DR. WORZALA: If you have the stomach for it.
15 Switching topics a little bit, we'll talk about two issues
16 under the outpatient PPS, the outlier payments and
17 transitional corridor payments. We discussed the conceptual
18 basis of outlier payments in October. I don't want to go
19 over that here. Briefly, we framed the outlier as a kind of
20 insurance, providing hospitals with financial protection in
21 the event of extraordinarily high costs in comparison to
22 their Medicare payment rates. The ultimate goal of that

1 kind of outlier provision is to protect access to care for
2 beneficiaries that incur extraordinarily high costs.

3 During this presentation I'll review the outlier
4 policy as it stands today, reiterate our policy questions
5 and present some data inform them. Then I have three
6 recommendation options for you to think about. Again, these
7 are options and I would appreciate your feedback on them.

8 On the second issue, transitional corridors, I'll
9 update you on the impact of the current legislation very
10 quickly, because we covered that this morning, but then also
11 give data from the cost reports on the importance of these
12 transitional corridor payments for different types of
13 hospitals. I would like your guidance on whether to pursue
14 that particular issue any further.

15 The outlier policy for the outpatient PPS is
16 required by statute. Like the outlier policy in other
17 settings it must also be budget neutral. Therefore, CMS
18 reduces payments for all APCs to fund the outlier payments.
19 Congress set an upper bound on the outlier payments of 3
20 percent. CMS has so far targeted outlier payments below
21 that limit. In 2003, the target was 2 percent and that will
22 be maintained in 2004. If actual payments exceed or fall

1 below that target amount, no effort is made to modify the
2 conversion factor to recoup or return over or underpayments.

3 In 2003, the outpatient PPS provided outlier
4 payments to all APCs except for pass-through drugs and
5 devices. This was regardless of the payment amount for the
6 service and includes both broadly defined APCs such as
7 surgeries, and narrowly defined groups such as an x-ray or
8 an echocardiogram. The recent Medicare legislation will
9 remove separately paid drugs from receiving outlier payments
10 effective 2004.

11 CMS estimated that a cost threshold of 2.75 times
12 the payment rate for the APC and a marginal payment factor
13 of 45 percent of the cost above the threshold would result
14 in outlier payments that meet the target of 2 percent. I
15 believe there's a discrepancy between what's in front of you
16 and what's on the screen with the cost threshold. It is
17 2.75 not 3.5.

18 How do the fiscal intermediaries calculate the
19 outlier payments? Basically, outlier payments are based on
20 estimated costs since those costs are estimated by the
21 fiscal intermediaries by multiplying current charges on a
22 claim by a cost to charge ratio from the most recent

1 tentatively settled or settled cost report. Even using that
2 most recent tentatively settled cost report generally
3 results in a time lag of one to two years between the
4 calculation of the cost to charge ratio and the submitted
5 charge on the claim. So if the charges have increased at a
6 faster rate than the costs since that cost report period,
7 the CCR will result in an estimate of costs that are higher
8 than the actual costs.

9 There are, of course, many reasons for a hospital
10 to increase charges faster than costs, and no matter what
11 motivation this pattern would result in unwarranted outlier
12 payments. Since this is a budget neutral system those are
13 paid for by other hospitals. Since the outliers are budget
14 neutral that has distributional effects.

15 This slide shows the historical relationship
16 between cost and charges since 1985. The metric here is the
17 ratio of cost over charges, so a lower value indicates that
18 charges are higher than costs. This is a CCR on this chart
19 for all patient care service not just outpatient services.
20 But what we're looking for here is the trend over time. You
21 do see a secular trend of charges rising faster than cost
22 among all hospitals. With any of these metrics there can be

1 variations across hospitals. We do know that there were
2 some hospitals that were very aggressive in raising their
3 charges.

4 So as I mentioned there is this time lag, which
5 means you are overestimating costs if you use an older cost
6 to charge ratio against the current charges on the claim.

7 CMS has done quite a bit to limited this problem.
8 They have required that the FIs update their CCRs whenever a
9 new cost report is submitted or settled. They give a very
10 short time window for the FIs to do that. And they have
11 changed a provision where if a CCR seems exceptionally low
12 they simply verify that that's the correct CCR rather than
13 substituting a state-wide average CCR. Nevertheless, this
14 problem is inherent in the calculation of outlier payments.

15 There's an additional issue that arises here
16 because the FIs are calculating a single hospital-level
17 outpatient-specific cost to charge ratio. We know, however,
18 that the relationship between costs and charges can vary by
19 service depending on the hospital charge structure and how
20 much they mark up one type of service over another. So if
21 one department routinely has a higher markup than the
22 average, the estimated cost for services in that department

1 will be overstated, and those services attract more outlier
2 payments. Then the opposite is true for a department that
3 has a lower markup.

4 One thinking about this, it's parallel in some way
5 to the coinsurance structure under the outpatient PPS where
6 coinsurance what was based on charges. If you look at the
7 coinsurance rates you see a rate closer to 50 percent for
8 things like imaging, departments where we think the markup
9 is higher versus other services, some of the clinic visits
10 and things where we think that the markup might not be as
11 high. So keep that in mind as I show you some of the
12 service level results in a few minutes.

13 What are our policy questions that we're trying to
14 address? First, does the outpatient PPS need an outlier
15 policy? Second, if it does, what is the appropriate design?

16 In October we discussed at some length this first
17 question. I'll quickly summarize the arguments here since
18 some time has elapsed. There are a number of reasons to
19 think that the outpatient PPS does not need an outlier
20 policy. First, there's a very narrow product definition and
21 we have many ancillary services and inputs such as drugs, x-
22 rays, that are paid separately, leading us to think that

1 variability in costs will not be great.

2 Second, the APCs have low payment rates, which
3 means that the size of the potential loss from any given
4 service is generally quite small even if it's very costly in
5 comparison to the payment rate.

6 Third, there are some equity issues. This is a
7 budget neutral system so the base payments have been lowered
8 to fund the outliers, and the outliers are not evenly
9 distributed. So there are some distributional effects. In
10 addition, there is potential for outlier payments to be made
11 in response to increases in charges, not necessarily
12 increases in costs. Again, since this is budget neutral it
13 may be more equitable in fact to have no outlier policy.

14 Finally, the outpatient PPS is the only ambulatory
15 care setting with an outlier policy, but many of the
16 services provided there can be provided in physicians'
17 offices or ASCs, so you're creating on more difference in
18 how we pay for these services across settings, which is a
19 larger payment question.

20 It despite those no arguments there are some
21 arguments to maintain the outpatient outlier. First, we do
22 see a shift toward more sophisticated and more costly

1 services moving to the outpatient setting, outpatient bone
2 marrow transplants, outpatient mastectomies, things that are
3 fairly significant procedures, in addition to cardiac
4 catheterization, implant of cardiac devices, those sorts of
5 things.

6 Second, the outpatient PPS is a fairly new payment
7 system. It's been a little bit difficult for CMS to set the
8 payments given the data that they have available and
9 hospital coding practices and those sorts of things, so the
10 outlier may be providing a cushion for rates that are
11 actually too low. It would be better to fix the payment
12 rates, and I think as the payment system matures there will
13 be less of an issue there. But in the interim, maybe the
14 outlier payment is serving a purpose there.

15 Third, we do see that there's a potential for
16 distribution of cases across hospitals that is not random.
17 Some hospitals may have more expensive cases on a routine
18 basis and the outliers would help cushion the impact of that
19 for those hospitals.

20 Moving on to the second set of design questions.
21 Here we're really looking at how, assuming we want to keep
22 an outpatient outlier policy, how would we determine

1 eligibility, how shall we set the threshold, and indeed, how
2 much funding should there be if we change either the
3 eligibility or the threshold? Very quickly, you've seen
4 this slide before. Most APC groups have low payment rates
5 per unit. Two-thirds have payment rates of less than \$500
6 and 75 percent have payment rates of less than \$1,000.
7 There are some high-paid services, insertion of a cardiac
8 defibrillator is about \$17,000.

9 Here we look at the services receiving the most
10 outlier payments in 2001. First of all, almost all APCs
11 received at least some outlier payments, but a relatively
12 small number, 26, accounted for 50 percent of the outlier
13 payments. These same services accounted for only 38 percent
14 of the payments. The nine services on this chart --
15 obviously I couldn't put all 26 on there. The 26 are in
16 your briefing materials. The nine on this chart account for
17 29 percent of the outlier payments and 25 percent of APC
18 payments.

19 In looking at this chart we see that the payment
20 rates for all of these services that are the top outlier
21 getters are low, under \$400. This first service that
22 received 6.6 percent of the outliers is infusion therapy

1 except chemo. We might expect considerable variation in the
2 cost for this particular service because there are packaged
3 drugs and infusion fluids in the payment rate and that may
4 vary quite a bit by patient. However, CMS is now paying
5 separately for many drugs and there's this floor under drug
6 payment amounts so moving forward we may not expect as much
7 variability for this APC.

8 The next two services, the CT and the x-ray seem
9 to have less intuitive rationale for variability in cost and
10 the need for outlier payments. I'm not quite sure what an
11 outlier CT is. One thing that I should say, however, is
12 that these are very common services. So for example, the x-
13 rays, where you see the share of the payments and the share
14 of outliers being the same, random variation could explain
15 that but I think we have a question of whether that the kind
16 of service that we want to protect given that it's a payment
17 rate of \$40.

18 MS. DePARLE: Chantal, can you walk through 0260
19 level one x-ray \$40. What does that mean? How do you
20 qualify for an outlier payment?

21 DR. WORZALA: You have costs that are -- we'll
22 just say that the threshold is three times, so you have

1 costs that are more than three times the payment rate. So
2 you're reporting costs from your x-ray that are \$40 plus
3 \$120, \$160 and then you qualify for an outlier.

4 MS. DePARLE: So for an individual patient your
5 costs were 2.75 times the \$40?

6 DR. WORZALA: Correct, and then we're paying a
7 fraction of the cost about that threshold.

8 MS. DePARLE: Clinically, what would have caused
9 that?

10 DR. WOLTER: I was just trying to figure out what
11 it might be.

12 DR. REISCHAUER: Couldn't all of your x-rays fall
13 into the outlier?

14 DR. WORZALA: Yes, all of your x-rays could fall
15 into the outlier.

16 DR. REISCHAUER: So it's a hospital that has very
17 high charges for this.

18 DR. WORZALA: Yes. Let's focus a little bit on --

19 DR. WOLTER: It probably wouldn't be worth knowing
20 although it may be that at that low a payment rate it just
21 doesn't matter, but you might wonder is it somebody in the
22 emergency room who has a neck injury and getting a c-spine

1 film is very difficult and it takes multiple views. You
2 could imagine some clinical reasons but I honestly don't
3 know.

4 DR. NELSON: I know you want to move on but while
5 we're on this subject with our hypothetical chest x-ray that
6 goes off the top of the chart, is the patient insulated from
7 -- in their copayment?

8 DR. WORZALA: Yes. Only the program pays an
9 outlier payment. The beneficiary only pays their copay.

10 DR. NELSON: So is the patient's copayment higher?

11 DR. WORZALA: No, it is not.

12 MS. DePARLE: So the patient's copay is only based
13 on \$40?

14 DR. WORZALA: That's correct. Focusing on the
15 cost to charge ratio, if we look at the electrocardiograms,
16 they receive 3 percent of the outliers and were only
17 responsible for 1 percent of the payments. The table in
18 your briefing materials has another column that looks at
19 outlier payments as a share of outlier plus APC payments.
20 For this particular service, 12 percent of the total flowed
21 through -- 12 percent of total payments for
22 electrocardiograms came from the outlier payments. I think

1 this may be an example of a service that has a higher than
2 average markup.

3 Moving onto outlier payments by hospital group,
4 we're looking at the distribution of outlier payments among
5 hospitals across three different groupings, location,
6 teaching status, and ownership type. In each group we're
7 seeing that one type of hospital received a greater share of
8 outlier payments compared to APC payments than others. It
9 doesn't, however, tells us why. These relationships could
10 be explained by differences in patient mix, could be
11 explained by differences in cost, it could be explained by
12 differences in charge structures. These numbers are from
13 2001. We have also just analyzed the 2002 data and we'll
14 bring those results to you in January.

15 The top right number there of 3.3 percent
16 indicates that in 2001, if you took outliers over the sum of
17 outliers plus APC payments the outliers were 3.3 percent of
18 the total. This is a ratio from the claims. There's no
19 transitional corridors. In 2001, the target was 2.5
20 percent, so it's slightly higher than the target. However,
21 when we look at the 2002 claims it drops down to closer to 2
22 percent. So I don't want people to take this away and think

1 there's a major problem. This was 2001. 2002 is closer to
2 2 percent. However, in both years the patterns across the
3 hospital groups are similar.

4 One other note, both of these two years precede
5 implementation of some of the steps that CMS has taken to
6 limit gaming, so the CCR calculation -- this involves older
7 CCRs I guess is what I would say.

8 So let me take your attention to the final column
9 which again is outliers as a percent of all payments. By
10 location, hospitals in large urban areas received 4 percent
11 of all payments from the outlier. For other urban and rural
12 hospitals it was lower, 2.6 or 2.7 percent. If you look at
13 it by teaching status, outlier payments accounted for 5.3
14 percent of payments to major teaching hospitals. It was
15 lower for the non-teaching groups or the other teaching
16 group. By ownership we see that the for-profit or
17 proprietary hospitals received 5 percent of all payments
18 through the outlier mechanism.

19 I also did an analysis looking at the distribution
20 of outlier payments as a share of all payments for
21 individual hospitals. Looking at that we see that 50
22 percent of hospitals had outliers that were 1 percent or

1 less of total payments, 75 percent had outliers that were 4
2 percent or less of total payments, and at the other extreme,
3 we had 1 percent of hospitals where outliers represented 30
4 percent or more of payments. There I only include the
5 hospitals we know from analysis from CMS, but for the
6 community mental health centers it was closer to a one-to-
7 one ratio of outliers to base payments. I also required
8 that the hospitals have at least \$1,000 in payments for that
9 analysis.

10 In summary, since I've shown you a fair amount of
11 data, we know that most outpatient PPS services are narrowly
12 defined and have low payment rates. We've seen from the
13 data that most of the services receiving the greatest share
14 of outlier payments have low payment rates and are narrowly
15 defined. The data also show that the distribution of
16 outlier payments varies by hospital group and individual
17 hospital. These differences could be due to differences in
18 patient mix, cost structure, or differences in charging
19 practices. It's probably a mixture of all three.

20 Finally, we think that the calculation of the
21 outlier payment makes it susceptible to gaming. Although to
22 be fair CMS has taken some steps to limit those

1 opportunities, but there is still nothing to stop a hospital
2 from taking a commonly-provided service and increasing their
3 charge for that particular service and getting some outlier
4 payments that way.

5 Given these conclusions I'll present you with --
6 I'm sorry, there's one other global comment I wanted to make
7 which is that looking at this data I'm not sure it's clear
8 that the outlier policy is really protecting hospitals from
9 large financial losses, at least in the bulk of the outlier
10 payments. Therefore, I'm not sure that it's having a lot of
11 impact on beneficiary access to care. We may not be making
12 outlier payments in cases where patients truly are more
13 costly I think is what I'm saying.

14 So with that context we have three recommendation
15 options. Again these are options. The first option is you
16 do this and you don't need to do the other two. The other
17 two you could do in some sort of combination.

18 The first recommendation option would be that the
19 Congress eliminate the outlier provision for the outpatient
20 PPS. The spending implications of this would be nothing.
21 The provision is budget neutral and presumably the funds
22 would go back into the base conversion factor. The impact

1 on beneficiaries and providers, it seems unlikely, given
2 what we've seen, that this would adversely affect
3 beneficiary access to care. But we do know that it would
4 redistribute payments among hospitals when you shift funds
5 to the base.

6 Recommendation option two read that the Secretary
7 should introduce a dollar threshold to the outlier policy
8 under the outpatient PPS. The Secretary was given authority
9 to do this under BBRA. The spending implications would be
10 none since it's budget neutral. I would think that this
11 would actually better protect beneficiaries with
12 extraordinary high costs because you could focus the limited
13 funds that are available in the outlier to those that are
14 truly extremely costly. It would probably result or may
15 result in a redistribution of outlier payments among
16 hospitals.

17 The third option takes a slightly different
18 approach to modifying the outlier policy looking at services
19 as opposed to a dollar threshold and it read that the
20 Congress should give the Secretary the authority to limit
21 the kinds of services eligible for outlier payments under
22 the outpatient PPS. Currently by law all services must be

1 covered unless stated otherwise in law, and we do have this
2 example of the separately paid drugs now not being eligible
3 for outlier payments. Here the spending implications, none;
4 and for beneficiaries and providers would probably better
5 protect beneficiaries with extraordinarily high costs and
6 may result in the redistribution of outlier payments.

7 MR. HACKBARTH: Questions, comments?

8 MS. ROSENBLATT: Just a quick comment. I think
9 the chart on page 10, the one that we were all getting
10 excited about leans me towards recommendation number three,
11 because if I look at 0612 high-level ED visit, just reading
12 that you would think there would be clinical differences
13 there. So I think option three captures that, that there
14 will be some. But like we were talking about the x-ray, I
15 don't buy that one. So I would vote for three.

16 DR. WORZALA: I just want to say one thing about
17 emergency services that I'm not sure I said. I did in the
18 paper, and I did another analysis in the paper that I didn't
19 even present here because I felt like it was data overload.
20 But the payment system for emergency services is that
21 there's a payment for the visit. So for the assessment, the
22 triage, that sort of thing. But everything that's done

1 during the emergency visit is also paid. So if you get a
2 cast, you need an x-ray, those services also ring the
3 register, as it were.

4 The analysis that I did on a claim-level basis as
5 opposed to a service-level basis was really trying to get at
6 this notion of whether or not outlier payments were
7 concentrated on people where you thought there would be
8 variability like emergency services. So I categorized each
9 claim as being an emergency visit first, hierarchical
10 determination, and then after that a major procedure, after
11 that chemotherapy, trying to say, why would you come to the
12 outpatient department. When you look at it that way you
13 still don't see that there's a lot of outlier payments
14 coming to emergency visits, which I thought was rather
15 surprising. It had an even outlier and total payment
16 percentage.

17 So conceptually you would think that was true.
18 The way the system is working currently it's not true. But
19 I did want to make clear that we're not talking about all of
20 the services provided in an emergency visit when we take
21 that code 0610.

22 DR. REISCHAUER: Why isn't it practical to have a

1 clawback provision that whenever an audited cost report is
2 completed you plug it into the computer and it goes back and
3 calculates the over or underpayment in the outlier system,
4 which would remove a tremendous of the incentive here? With
5 interest.

6 DR. WORZALA: I believe that is being done for the
7 inpatient outlier. On the outpatient side we do have
8 millions and millions of claims, so I think it would be a
9 fairly significant administrative effort to do that. It's
10 certainly not impossible.

11 DR. REISCHAUER: That's why you have computers.
12 They do these kinds of things for you.

13 DR. MILLER: Do we have any sense of -- this is
14 probably not a fair question but do we have any sense of how
15 many and how long it takes for completing an audit report?

16 DR. REISCHAUER: So what? You're removing the
17 incentive.

18 DR. MILLER: Eliminating it would too.

19 MR. HACKBARTH: Let me ask this. Is there any
20 sentiment in favor of just eliminating outlier payments,
21 which I think was option one on Chantal's list? Any
22 sentiment in favor of option one which was to eliminate

1 outlier payments altogether for these services?

2 MS. DePARLE: It would just mean that the 2
3 percent would be preserved in the spending on outpatient
4 services?

5 MR. HACKBARTH: Yes, go back into the base. So it
6 would have distributive implications but not aggregate
7 spending implications.

8 MS. DePARLE: Alice made the most compelling case.
9 Sitting here looking at it I'm embarrassed that we even
10 implemented this, frankly. I don't understand it.

11 DR. WORZALA: Don't be too embarrassed. The
12 proposed rule didn't have an outlier and it was mandated by
13 Congress.

14 MR. HACKBARTH: I guess I'd worry some about there
15 being some variability, particularly in the services that
16 involve larger bundles, so to speak. The cost to charge
17 ratio is just so problematic that I wonder whether we do
18 more harm than good using that mechanism. It rewards gaming
19 of the system and the dollars just may not be getting to the
20 right place at all.

21 MS. ROSENBLATT: In small amounts you're
22 multiplying by three. It's pretty easy to get there it

1 sounds like.

2 DR. WOLTER: I suppose one option would be to
3 combine two and three and suggest that a more limited
4 universe of outliers be created looking at services and
5 dollar bundles so that there's still some flexibility and
6 yet we're moving in the direction of taking a lot of the
7 gaming out of the system especially for the small dollar
8 numbers.

9 MS. DePARLE: Nick, I hear you but the agency has
10 to implement all this stuff in the Medicare bill plus a
11 prescription drug benefit. Is it really worth it? Is this
12 achieving -- I guess we need to hear from some hospitals
13 that think it's really doing something to help them meet the
14 needs of their patients. But so far I don't think this
15 would be worth having spent at CMS spend time trying to get
16 this right.

17 MR. MULLER: First of all, I would say that, as
18 Chantal's presentation indicated, we're finding out some
19 data on '01 now, so I think the outlier provision was put in
20 more when we didn't know what was going to happen. If we go
21 back three years there's incredible uncertainty as to what
22 actually was going to happen, whether the APCs were even

1 remotely on target or not. We had all those corridor
2 payments and hold-harmless and all that kind of stuff, as
3 you know. So I think now three years later we know a little
4 bit more about it and it turned out to be a little closer to
5 where people hoped it would be as opposed to just being way
6 off the mark in terms of meeting costs and so forth.

7 So I think this probably less thrust for it now
8 than there would have been three years ago when there was
9 all kinds of uncertainty. So in some ways, one way of
10 making an argument against it in some ways is saying, three
11 years later, now that we have some data on 2001, it doesn't
12 seem that we were as far off as we might have thought we
13 were and we made all those kinds of protections. I think in
14 some ways there was a fear that on some of these services
15 one could be off 50, 80, 100, 200, 300 percent, and there is
16 not substantial evidence that that in fact has occurred. So
17 that in many ways could be a persuasive argument for saying,
18 doesn't seem to be as big a problem.

19 On the other hand, not all these are totally
20 narrowly defined and the purpose, as Glenn just said, of
21 having outliers sometimes -- we have 570 APCs, we have 510
22 DRGs, so it isn't as if -- to use arithmetic, to use the

1 phrase of the day -- the bundles aren't that much more
2 narrow than some of the DRG bundles and so forth. So you
3 could make an argument by having some possibly, and one
4 thing to do is just you can kick the threshold up even more,
5 is one way of really making a note for the very extreme
6 cases. So I think having a couple suggestions on that, but
7 I think one fair statement is this is the first time I've
8 really seen data on this in terms of what happened in '01 so
9 I think letting people start understanding what actually
10 happened is going to be helpful.

11 MR. HACKBARTH: The problem, of course, with just
12 kicking up the thresholds is you're still relying as your
13 basic took on the cost to charge ratio which is so
14 problematic, which is I'm sure where Bob's coming from in
15 saying, if you can do something that would reduce the
16 opportunity, the incentive to manipulate that number, that
17 would give you some confidence then you could have a system
18 maybe with higher thresholds and it be reasonably fair. But
19 right now it's just --

20 MR. MULLER: You have a cost to charge ratio for
21 the whole hospital. You don't have it -- you can't do one
22 on cardiac and another one on oncology. You can't just

1 manipulate it that way.

2 MR. HACKBARTH: The graph that Chantal showed,
3 over the last 15 or 20 years, the decline in the aggregated
4 cost to charge ratio from 75 down to 42, that just screams
5 at you this is a giant game. If we continue on this rate
6 for the next 15 years we're approaching zero on our cost to
7 charge ratio.

8 DR. REISCHAUER: Even if you did what I suggested,
9 you could manipulate the cost to charge ratio for services
10 that were heavily used by Medicare patients versus other
11 ones and the hospital's ratio on average would be a biased
12 thing, so there's still a game to be played.

13 MR. HACKBARTH: So I think I hear consensus that
14 the status quo is not desirable and we need to make a change
15 here. The options on the table are eliminate completely or
16 maybe do a combination of two and three, which is focus on
17 our services with some variability and have the front-end
18 threshold.

19 DR. WORZALA: We can also pick up Bob's suggestion
20 of asking the Secretary to settle the outlier payments on
21 the cost report, which is what they're doing on the
22 inpatient side. But before we do that I would like to

1 better understand what that would entail on the part of the
2 agency and the FIs.

3 DR. REISCHAUER: We could mix all three and have
4 this phase out but in the first stage being we raise the
5 threshold, give the Secretary a little bit of flexibility to
6 bump out some things that shouldn't have a lot of
7 variability, reduce the aggregate to 1 percent or something
8 like that, and then three years have it disappear.

9 MR. HACKBARTH: We don't need to resolve this
10 today. Any other thoughts that people want to give Chantal
11 to look at in the next month?

12 Okay, thank you very much.

13 DR. WORZALA: Actually I forgot until Sarah
14 mentioned that there's some data on transitional corridor
15 payments. Do you have the stomach for that after all this?

16 MR. HACKBARTH: Sure.

17 DR. WORZALA: I think I will skip over the set-up
18 for the transitional corridor payments unless anyone feels
19 like they need a review of what they are or how they work,
20 and get to the data since again this is something that has
21 not been seen. One thing I will point out is that the
22 calculation of the transitional corridors is also dependent

1 on the cost to charge ratios because we first must estimate
2 the cost in calculating the payment, and there's an interim
3 payment with settlement on a cost report.

4 These are data from the 2001 and 2002 cost
5 reports. What I'm looking at here are the share of PPS
6 payments that came through transitional corridor payments.
7 So it's transitional corridor payments divided by PPS
8 payments plus transitional corridor payments. The 2001
9 number I believe is about 95 percent of hospitals. 2002 is
10 60 percent with no imputation for missing hospitals.

11 We can see that altogether in 2001 these payments
12 represented about 2.3 percent of all payments, rising to 2.6
13 percent in 2002. That compares to a projection of 4.4
14 percent on the part of CMS when they put the rule out. So
15 we might conclude that hospitals are actually doing better
16 transitioning into the PPS than was expected.

17 Alternatively, you could say that the data available to CMS
18 when they made that estimate wasn't the best and they did
19 the best they could with the data and there's a difference
20 there.

21 It's a bit surprising to see an increase in the
22 transitional corridor payments rather than a decrease since

1 the policy is supposed to be phasing down traditional
2 corridor payments. That trend may not hold with a full
3 sample of hospitals. But it could be a real phenomenon if
4 the difference between PPS payments and payments estimated
5 from previous payment policy grew by a fairly substantial
6 amount between those two years. Again that would involve
7 cost to charge ratios and payment to cost ratios in making
8 those calculations.

9 If you look at these shares you see that small
10 rural hospitals received a greater share of total PPS
11 payments from transitional corridors. The rural one to 100
12 beds, it was 4.7 percent in '01 and 6.4 percent in '02.
13 Also we see that the major teaching hospitals report a
14 higher share of payments from transitional corridors as
15 well, about 5 percent in each of the two years.

16 As we talked about this morning, the current
17 legislation does extend those hold-harmless payments for the
18 small rural hospitals for two years and also extends them to
19 all sole community hospitals regardless of size. About 85
20 percent of the sole community hospitals have 100 or fewer
21 beds. It also requires a study by the Secretary of the cost
22 of rural hospitals compared to urban under the outpatient

1 PPS and a look at the need for a payment adjustment for
2 rural hospitals.

3 We had put this on our agenda for this year
4 because our 2001 report suggested that there may be some
5 factors that would make the outpatient PPS more difficult
6 for small rural hospitals to adjust to. We've been a little
7 bit frustrated over the last two years that there hasn't
8 been any data, which we now have of course. But I don't
9 know that, given the current legislation, the Commission
10 wants to do anything else with. So I bring that for your
11 direction.

12 MR. HACKBARTH: Comments?

13 DR. WOLTER: A question. I didn't quite catch
14 that. The legislation extends this to sole community
15 hospitals; is that what you said, or what bed size?

16 DR. WORZALA: Any bed size. However, about 85
17 percent are 100 or fewer beds. So there are about 15
18 percent of small community hospitals who will benefit from
19 this provision that didn't previously, so it comes with a
20 small price tag.

21 MR. HACKBARTH: I'm sensing that we're at the end
22 of our useful life for today. We're going to take this

1 other advisement I think it and retire to our chambers.

2 Thanks, Chantal.

3 DR. WORZALA: Please let me know if you want
4 additional analysis by January.

5 MR. HACKBARTH: We'll have a brief public comment
6 period.

7 MS. FISHER: Karen Fisher with the Association of
8 American Medical Colleges. I wanted to jump in first
9 because my comment relates to your most recent topic on the
10 outliers. I'm going to continue the analogy of not doing
11 math in public, I'm nervous because I've been thinking and
12 I'm going to think in public here and that may not be a wise
13 thing.

14 The issue of the outlier payments, first of all I
15 would say teaching hospitals are in favor of accurate costs
16 because teaching hospitals, we believe, tend to treat the
17 complicated cases. When you look at accurate costs -- and
18 that's the intention of the outlier payments. When you have
19 a set pool of money, if there are people who don't have
20 accurate costs, it takes money from those who have accurate
21 costs for high-cost cases.

22 There's the issue of what do you do with the cost

1 to charge ratios, et cetera. The inpatient outlier final
2 rule last year -- and I've been informed by my colleagues
3 that this whole issue of using more recently settled and
4 submitted cost reports to try to eliminate the lag period
5 with cost to charge ratios we think is going to eliminate a
6 lot of the gaming that was associated with the outlier rule.

7 The issue of going back for egregious people and
8 trying to settle I also hear from my colleagues is limited
9 to the inpatient only, and I think it's a reasonable thought
10 for this Commission to think about on the outpatient side.

11 I would say that we also have to remember that CMS
12 has shown that for high-cost services the markup tends to be
13 less than for overall services. So when you look at that
14 cost to charge ratio and you look at the high-cost,
15 complicated services, this issue gets a little bit more
16 complicated because the markup is not as high for those
17 services.

18 I'm a little quizzical about the impact on the
19 beneficiaries under the three options. It seems to my under
20 option one, to eliminate it, we're not sure what the impact
21 is on the beneficiaries because we're not sure what the
22 impact of eliminating the outlier policy would be on the

1 low-volume, high-cost services because they don't show up in
2 the outlier tables contributing to the large amounts of the
3 outlier payments.

4 On the second two options we say it better
5 protects beneficiaries if we limit it to higher-cost
6 services or to a certain set of services. I would say that
7 if you just do that it would have no impact on beneficiaries
8 because that's what's occurring now. It's occurring now for
9 those high-cost services as well as the low-cost services.
10 What would better protect beneficiaries though is that if
11 you limited the number of services that would be eligible
12 for an outlier payment but then increase the outlier payment
13 threshold, which is currently at 45 percent, we believe that
14 if you're truly dealing with accurate costs and you're
15 limiting the outlier payment policy to the high-cost
16 services, why are you only paying for 45 percent of the
17 costs above the threshold, which is already twice what the
18 cost amount is? So it's quizzical why you wouldn't increase
19 that threshold.

20 We would suggest if you go down a path of limiting
21 the number of services and the types of services that would
22 be eligible for an outlier payment that you give serious

1 consideration to increasing the outlier payment percentage
2 that those services would be eligible for.

3 We're also concerned because if you again look at
4 the data and believe that major teaching hospitals tend to
5 provide a number of these services and then you look at the
6 transitional corridor payments which are going to be
7 eliminated for major teaching hospitals at the end of this
8 year, and if you believe some of the reason for the
9 transitional corridor payments is because they're providing
10 high-cost services, the need for an outlier payment policy
11 in the future is more important than ever.

12 Thank you.

13 MR. ARMSTRONG: I'm Doug Armstrong. I'm with
14 AAHP-HIAA. We are the nation's trade association
15 representing about 1,300 of the nation's health insurers,
16 including those that provide coverage to more than 200
17 million Americans. I'd like to say that I'm having a little
18 bit of difficulty in reconciling the inequitable way that
19 the Commission is recommending incentives for quality. This
20 morning the Commission recommended withholding 2 percent of
21 all plan payments and then rewarding only those certain
22 plans that meet or exceed certain quality thresholds. While

1 this afternoon the same commission recommended withholding
2 just 0.4 percent of inpatient payments and then returning
3 them to all facilities that only have to meet reporting
4 requirements with no accountability whatsoever for meeting
5 or exceeding any sort of threshold. This seems to be very
6 inequitable, and it is.

7 What it actually does is it completely
8 discriminates against one portion of the health care
9 delivery system and that's the insurers. I know that we
10 would greatly appreciate you re-examining what you're using
11 as carrots and sticks as providing incentives for quality
12 throughout the health-care industry.

13 MR. MAY: Don May with the American Hospital
14 Association. I want to thank you for a very rich and lively
15 discussion today that kept the room pretty full even if we
16 are at the end of our useful life for the day. A couple
17 things. One on outpatient, to start there and the outlier
18 provision.

19 I think we feel, as Karen mentioned, that there
20 does need to be an outlier provision. Outpatient services
21 are changing. Many more things can be done on an outpatient
22 basis. We don't know what the cost of those are going to be

1 and it probably makes sense to have an outlier policy.

2 That being said, having it pay at a very discrete
3 level, at a very small bundle probably doesn't make as much
4 sense as expanding -- either by setting a higher threshold
5 or by looking at all the services provided on one day. I
6 don't know if that's at a claim level, because I know the
7 data is very complicated, but in a visit, when you come to a
8 hospital, maybe look at what the costs are for that day,
9 accumulating the cost for a visit, regardless of how many
10 APCs are there, see if that was a high-cost patient because
11 of all the multiple things that had to be done and then
12 compare what the payments were to try to get at a better,
13 reasonable outlier system in the outpatient program.

14 Like Karen, I think that a lot of the changes that
15 CMS has made around cost to charge ratios and using more
16 current data to get there has gone a long way and will go a
17 long way in addressing some of the data concerns that show
18 in this old data, but this old data, as she mentioned,
19 doesn't reflect some of the changes in policy.

20 I would say, however, that we would very much urge
21 you not to recommend cost settlement of outpatient claims.
22 That would require regenerating every single claim using new

1 cost to charge ratios, and there are many, many more
2 outpatient claims than inpatient claims. It would be a
3 very, very burdensome approach at looking at outliers and is
4 something that we would be very concerned about that excess
5 burden put on the system.

6 On to payment adequacy and the update
7 recommendation. When I look at the data and I look at
8 Medicare margin dropping every year since 1997 I look at the
9 trend in the overall Medicare margin dropping and the
10 projection for it to drop in 2004 again. What I see is
11 declining payment adequacy and really we don't have payment
12 adequacy in Medicare. That's why Congress passed a
13 prescription drug bill with many provisions in it to help
14 rural providers, other providers, other hospitals, because
15 the payment adequacy isn't there. You have more than half
16 the hospitals in the country losing money providing care to
17 Medicare patients. That is inadequate.

18 When you look at that aggregate and you say it's
19 at 4 percent or 3 percent or now it's at 2.4 percent and
20 things are still adequate, that does not take into account
21 the variability and it doesn't allow you to move toward
22 where we need to go in improving the technologies in our

1 hospitals, the information systems, building average age of
2 plant, which is at its oldest in years. So I really would
3 urge you to rethink what we're determining is adequate
4 because I don't see adequacy in those numbers.

5 As far as the whole cost allocation issue, I think
6 we heard today arguments for the cost allocation is still an
7 issue, arguments by the same staff that cost allocation may
8 not be an issue. I really think we should just start
9 showing the margins. The home health margins in hospitals
10 are deplorable. That's why we have hospitals getting out of
11 that service. They can't afford to provide the service.
12 Regardless of how you look at cost allocation, hospitals and
13 organizations are making decisions based on whether they can
14 afford to stay in that line of business, whether they can
15 afford to do that for their communities, and clearly they
16 can't. So cost allocation aside, the home health margins by
17 hospital-based providers are falling and dropping and that's
18 why hospitals aren't able to provide those services.

19 If you look at some of the blanket terms on
20 capital, access to capital is still a struggle for many
21 hospitals. More bond downgrades than upgrades, and with a
22 downgrade comes, even if you have investment grade, more

1 expensive cost of capital. We just showed the cost of
2 capital was going up. That is a reflection that hospitals
3 have reached a point where they have to invest in their
4 infrastructure. They're doing it at a higher rate. So I
5 really would challenge the Commission and the staff to look
6 at some of the access to capital arguments because we really
7 do see with half the hospitals not having positive Medicare
8 margins, a third of the hospitals losing money overall,
9 there really is an access to capital problem. With all of
10 the demands on hospitals to improve infrastructure, to
11 improve information systems, to address some of the quality
12 and patient safety issues, these are very expensive and
13 those cost increases are very real.

14 On the science and technological advancements, and
15 this is particularly for outpatient but I think it applies
16 to inpatient as well. While there are some mechanisms to
17 pay for certain clinical devices or new drugs, remember that
18 science and technological advancement and the science and
19 technological advancement in health care that's going to be
20 the breakthrough that will all of a sudden allow us to lower
21 length of stay again is not necessarily just a drug, but it
22 could be information systems, it could be other things in

1 the hospital that aren't necessarily tied to a service but
2 may be tied to many services. I'd encourage the staff when
3 they talk about science and technological advancement to
4 really talk about all of science and technology, not just
5 the clinical components.

6 On productivity, we continue to be very concerned
7 about the use of the productivity adjustment, the 0.9
8 percent reduction of the general economy's multifactor
9 productivity growth. To think that one industry can
10 continue to have productivity gains year after year after
11 year is probably asking a lot. That general economy is
12 based on the cumulation of all the industries going up and
13 down on an annual basis. But to expect that the health care
14 field and hospitals in general should be able to hit that
15 every single year I think is somewhat ambitious.

16 I also believe, and we've been doing some work on
17 this issue, that when you look at the industry, health care
18 and hospitals are very labor intensive. There's a lot of
19 evidence out there that suggests that the more labor
20 intensive an organization is, the much more difficult it is
21 to have the same types of productivity gains for lower labor
22 related industries. I think, based on some of our

1 preliminary work, the general economy may be overstating by
2 as much as twice the rate of productivity that can be gained
3 in an industry that heavily relies on labor. You saw those
4 labor costs driving up cost of hospitals; the 6.6 percent
5 increase, the cost that Jack suggests might be happening in
6 2002 primarily being driven by labor.

7 I would argue that it's very difficult to suggest
8 that there is going to be a productivity adjustment of 1
9 percent when you've got such a labor-driven group, yet we're
10 going to take away billions of dollars with that adjustment
11 assuming that we can just take out 1 percent out of -- in
12 productivity on an annual basis when it is something that's
13 focused on labor.

14 But those are just some of the comments. We will,
15 obviously, be sharing more information on this productivity
16 analysis. We'd just encourage you to rethink about this
17 issue of payment adequacy and whether with a productivity of
18 minus 1 percent really make sense given the cost trends that
19 we're seeing.

20 Thank you.

21 MR. HACKBARTH: Thank you. We reconvene at 9:00
22 a.m.

1 [Whereupon, at 5:48 p.m., the meeting was
2 recessed, to reconvene at 9:00 a.m., Friday, December 5,
3 2003.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 5, 2003
9:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
NANCY-ANN DePARLE
DAVID F. DURENBERGER
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

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MR. HACKBARTH: Good morning. Our first topic for this morning is quality of care.

MS. MILGATE: What we're going to do in this session is provide you some data on the quality of care Medicare beneficiaries receive. We're excited about presenting these data for, as a recent article noted, surprisingly little has been written or presented about the quality of care Medicare beneficiaries receive, even though they represent 40 percent of all health care expenditures.

While the data we'll present to you do not provide a comprehensive view of beneficiary quality, they do include information on clinical effectiveness, patient safety, timeliness, and the patient-centeredness of care, which are the four primary dimensions that the IOM has identified as the dimensions of quality.

The data here are primarily on hospitals and ambulatory care so inpatient and ambulatory care. However in the chapter we will be presenting more information than just this information on hospitals and on physicians. For example, we'll be including the QIO data that CMS has collected on clinical effectiveness through the process

1 measures that they collect. And we'll also be hopefully
2 presenting upon the data, we're having some data issues with
3 our ACE-PRO analysis, that looked at the provision of
4 clinically necessary services in the ambulatory setting.

5 We will also be including in the March chapter on
6 quality, some information on quality and home health
7 agencies, skilled nursing facilities, dialysis facilities,
8 and Medicare+Choice plans.

9 These data are useful to the Commission for
10 several reasons. First of all, it helps us examine care in
11 specific settings. But I think, as the discussion showed
12 yesterday, there's a lot of interest in how we might go
13 forward and continue to find ways to put in place incentives
14 in various settings to improve quality. So it also gives us
15 some sense of what settings might be most important to
16 target, as well as the types of quality problems within
17 those settings that would be important for any incentives
18 program to actually focus on.

19 The third reason that we feel this information is
20 useful to the Commission is that we have in our quality
21 agenda wanting to explore the relationship in various
22 settings between the cost of care and the quality of care to

1 really look if there is a relationship or not or what that
2 relationship looks like. As you may recall, we did that
3 last June in the dialysis facilities and we were hoping to
4 also explore that in home health and SNF for this June
5 report. So this gives us also some indicators that we could
6 use for that project.

7 So let's go ahead.

8 First of all, what are the indicators we're going
9 to look at? Before we go any further on what they actually
10 are, I think it's important to note that it really would not
11 be possible to be presenting these data or to be looking at
12 administrative data in this way without the leadership of
13 John Eisenberg and then continued with Carolyn Clancy at the
14 Agency for Health Care Research and Quality. I think it's
15 important to note that all four of these indicator sets were
16 developed by AHRQ over a period of several years and they
17 have now become very useful for applying them to the
18 Medicare program.

19 The first three data sets provide information on
20 mortality by condition and procedure, patient safety, and
21 potentially avoidable admissions. They were designed to run
22 on administrative data, first of all by AHRQ to run on their

1 dataset, which is the Health Care Cost and Utilization
2 Project data, which is hospital discharge data that's
3 reported to the states. I think they have about 30 states
4 in their database now.

5 But the folks that developed these sets were also
6 instructed to make sure that the indicators were able to run
7 on any type of administrative dataset, so that it would be
8 possible for people like ourselves to take this and also run
9 it on Medicare claims. Which is what we did.

10 The claims that we ran them on was the MedPAR
11 file, which is the hospital discharge file. We ran it on
12 100 percent of all claims in the hospital file because many
13 of the patient safety indicators are very small. There's a
14 very small rate and so it was really important for us to be
15 able to actually get a larger sample for those. So we ran
16 everything that we did then on the 100 percent if MedPAR.

17 We did exclude some of the indicators that were
18 not relevant to Medicare, such as those that applied to
19 pediatric care. And then a very few of them we found when
20 we ran the data had very low occurrence. And so we don't
21 present the data for those here. So those are the
22 difference between what we did and what AHRQ did, in terms

1 of the actual indicators we included.

2 I also wanted to note, particularly on the first
3 two, the mortality and the patient safety indicators, that
4 these are, of course, a different data source than you'll
5 find in the QIO data. The QIO data are based on medical
6 record abstractions. So usually you have smaller samples,
7 they're harder to collect. But as Nick points out, in fact,
8 possibly provide a little bit more direct information to
9 hospitals on what they might do to actually improve on those
10 indicators. But they are somewhat different and I just want
11 people to keep that in mind as we go through our discussion
12 as what you might do with these indicators and these data
13 that we have.

14 MR. DURENBERGER: [off microphone.] Karen, could
15 you explain that, the importance of that?

16 MS. MILGATE: The importance of the distinction, I
17 guess, is I assume people will use some of these indicators
18 to say well, hospitals should maybe report this or would we
19 base an incentives initiative on these data or that data.
20 And I just want it to be clear that the data that we ran,
21 basically you can collect separate from requiring the
22 hospital to do anything, because it's simply a part of their

1 claims process to get paid, that they report information
2 that is coded in the ICD codes.

3 And then what AHRQ did was take various ways of
4 putting those codes together to say patients that were coded
5 this way should be excluded. And that they develop their
6 mortality rates. So someone else can actually extract the
7 data, read it, and see how useful it is.

8 The QIO data is, in some ways, for quality
9 measurement -- I don't know if I want to use the term more
10 precise. But it's things like did you give a beta blocker
11 when you should have, hospital? So they are, in some ways,
12 a step up in that they aren't indicators that a problem
13 could be there. They actually are measures of something
14 that should have happened. So they give the hospital the
15 ability to change something more directly. But they still
16 both measure problems. They're harder to collect because
17 the hospital has to go into the record or somebody and find
18 those things. So it's just much more burdensome but
19 provides probably more precise information.

20 The fourth set here is a survey which we spoke
21 about at the October meeting and also Cristina talked about
22 in her presentation on physician access yesterday. And

1 that's the CAHPS survey, the Consumer Assessment of Health
2 Plans Survey. This was originally developed by AHRQ for
3 private plans and then revised so that it could then be
4 applied to Medicare+Choice plans, and then revised again so
5 it could be applied to Medicare fee-for-service.

6 So what this gives us, because it's such a large
7 survey, so it's between 100,000 and 120,000 beneficiaries
8 are surveyed every year, at least they have been for the
9 last three, is some pretty good information on how
10 beneficiaries perceive their access and quality of care. So
11 we presented some information on access at the October
12 meeting, and here we'll be presenting some information from
13 the questions that relate more directly to quality in this
14 meeting.

15 You see before you the team of folks that have
16 looked at these data. So each of us will report on a
17 particular indicator set. Sharon?

18 MS. CHENG: The first set of indicators that we
19 have here this morning are for inpatient quality. Inpatient
20 hospitals are certainly an important setting in which to
21 measure quality. They provide about 10 million
22 hospitalizations to Medicare beneficiaries annually.

1 This set of indicators reflects the quality of
2 inpatient hospital care by measuring the rate of death among
3 beneficiaries in the hospital and 30 days from admission to
4 the hospital. The indicators on the screen here are ordered
5 by the number of in-hospital deaths, which is shown in the
6 last column.

7 We measured it two ways, in-hospital and 30 day.
8 The in-hospital mortality is perhaps more directly
9 attributable to the hospital because it's all within the
10 hospital setting. The 30-day rate could indeed be
11 influenced by the quality of settings that a beneficiary
12 uses after a hospitalization, especially post-acute care
13 providers. But it's also a useful way to look at mortality
14 because it's going to be less affected by the discharge
15 patterns of the hospitals, whether there's a short or long
16 stay for that beneficiary, determining whether they would
17 experience mortality 30 days after the admission in the
18 hospital or whether they were discharged and experienced it
19 outside the hospital.

20 MR. HACKBARTH: Sharon, could you remind us why
21 these? Why this list of eight, as opposed to some other
22 list of eight?

1 MS. CHENG: AHRQ chose these particular types of
2 mortality because of the evidence that they could gather for
3 these mortality. They're a little bit of a mix. The top of
4 the list are conditions. The bottom of the list are actual
5 procedures.

6 For each one of these there was a bulk of evidence
7 that showed that the rate of mortality did vary with some
8 aspect of the hospital. In general, that aspect was volume.
9 Higher volume hospitals with similar patients had a lower
10 rate of mortality. But also, especially for some of the
11 procedures, there was evidence that linked the procedures in
12 the hospital to the rate of mortality for similar patients.
13 I'm going to talk about that a little bit more in the next
14 slide.

15 MR. HACKBARTH: And these represent what
16 percentage of Medicare admissions?

17 MS. CHENG: I have to get back to you with the
18 number. They're pretty common admissions so it's a large
19 portion of hospitalizations.

20 The rates of mortality here are risk adjusted by
21 age, sex, and the severity of the patient's condition using
22 the APR-DRG measure of severity.

1 In summary, the in-hospital mortality rates
2 improved across the board from 1995 to 2000, which is to say
3 that the rate of mortality dropped for each indicator that
4 we measured. The most substantial improvements occurred for
5 CHF and for GI hemorrhage.

6 The 30 day mortality also improved for every
7 indicator except two: pneumonia, which was the most common
8 precedent of mortality among those that we measured and for
9 craniotomy.

10 Patients with the same condition or procedure die
11 outside the hospital more frequently than in the hospital.
12 The greatest difference between the in-hospital rate and the
13 30 day rate occurred for patients with CHF. There were two
14 exceptions to this pattern, for AAA repair, which is
15 abdominal aortic aneurysm and for CABG.

16 The trend in these mortality rates from 2000 to
17 2002 is the same trend as from 1995 to 2002 for in-hospital
18 mortality. However, all but one of the 30 day mortality
19 rates increased from 2000 to 2002, the opposite of the
20 longer-term trend.

21 As we suggested, they chose these mortality rates
22 because of the evidence that was behind them. In most cases

1 that was volume. In some cases that was a procedure. For
2 example, evidence showed that surgical teams that could
3 reduce the time to cross-clamping the aorta during a CABG
4 procedure reduced the mortality for similar patients. For
5 teams that used an epidural anesthesia instead of a general
6 anesthesia during hip replacements could also reduce
7 mortality among their patients.

8 So to the extent that mortality indicators reflect
9 the clinical effectiveness of hospitals, we can conclude
10 that quality has risen from 1995 to 2002.

11 Next, David and Karen will present evidence that
12 while quality in terms of clinical effectiveness appears to
13 be rising, quality in terms of patient safety or the quality
14 of ambulatory care that could prevent hospitalizations seems
15 to be moving in the opposite direction.

16 DR. REISCHAUER: Just a clarification, the
17 pneumonia category there, there are just people who have
18 been admitted to a hospital with pneumonia, as opposed to
19 all of the Medicare patients?

20 MS. CHENG: That's right.

21 DR. REISCHAUER: So in that case, obviously not
22 for some of the others, you can have changes in behavior for

1 admission for this diagnosis?

2 MR. HACKBARTH: [off microphone.] Sicker patients
3 are being admitted.

4 MS. CHENG: Right, although to try to capture some
5 of the effect that a changing population could have, that's
6 why we did try to risk adjust -- we used 2000 as the base
7 year and then we kept the age, sex, and APR-DRG of the
8 patients constant. So to the extent that that was
9 successful, we're seeing a real trend and a change.

10 MR. GLASS: Now looking at the patient safety
11 indicators we see a different story. This slide shows eight
12 of the 13 patient safety indicators we analyzed for
13 hospitals with Medicare discharges. Again, they're ordered
14 by the number of observed adverse events in 2000.

15 It shows the change in the risk adjusted rate from
16 1995 to 2002. The changes in the rate of adverse events per
17 10,000 eligible discharges, and for each indicator those
18 eligible only include certain discharges that were at risk
19 for the adverse event.

20 Further, some discharges were excluded to be sure
21 that the complication observed was a result of what happened
22 in the hospital and wasn't present at admission. For

1 example, decubitus ulcers only include stays of over five
2 days and exclude admissions from other institutions for
3 patients with a paralysis. So these, again, were developed
4 by AHRQ and they've tried to isolate what was going on to be
5 what was happening in the hospital.

6 As you can see, the rate for seven of the eight
7 indicators increased from 1995 to 2002. Overall, nine of
8 the 13 indicators showed increases and four showed
9 decreases, as the table that is in your mailing materials
10 shows in detail.

11 The four indicators with decreasing rates include
12 the two resulting in death, failure to rescue which is
13 second there and death and low mortality DRGs, which isn't
14 shown. That occurred about 3000 times. This accords with
15 the decline in mortality, especially in-hospital mortality
16 that Sharon discussed.

17 So while it's evident the rate for most of these
18 indicators has increased, we cannot say why. Although we've
19 risk adjusted these numbers by age and sex and
20 comorbidities, it is possible that severity has increased
21 for the population considered for each indicator. So we
22 didn't do the APR-DRG risk adjustment on these because that

1 would have interfered with what they were actually trying to
2 look at, which was complications resulting from the primary
3 diagnosis.

4 Most of the rates are relatively rare events with
5 rates under 100 events in 10,000 discharges. So one way of
6 looking at that is that post-operative sepsis, if you have
7 7000 events in 2000 and say you look at 3000 hospitals
8 excluding the smaller ones, that's only two or three per
9 hospital if they were evenly distributed. So these are rare
10 events and that might affect how we want to use this going
11 forward.

12 The pattern of increases and decreases, the same
13 looking at the changes from 2000 to 2002 as it was from 1995
14 to 2002. So it's not a passing phase.

15 Now Karen will look at the next set.

16 MS. MILGATE: What you see in front of you here
17 switches gears a little bit. While it uses hospital
18 discharge data to create these indicators, this is really an
19 indicator of the quality of care, or it is trying to be an
20 indicator of the quality of care of ambulatory care. So
21 this looks at the outcomes of poor ambulatory care by
22 looking at admissions to the hospital that could possibly

1 have been avoided.

2 These are conditions for which evidence suggests
3 optimal ambulatory care could have prevented, at least in
4 part, some of these admissions.

5 Now it's important to note that it's really hard
6 to assign accountability for poor ambulatory care because
7 there are so many different factors that affect the type of
8 care that patients get outside of the hospital. This could
9 be due, for example, to access to appropriate ambulatory
10 care. It could be that patients are actually getting into
11 see physicians but then not getting the appropriate care
12 management. As we know, there are also some lifestyle
13 issues with how, for example, weight gain or smoking could
14 affect a patient's admission to a hospital.

15 In addition, there are two of these, chronic
16 obstructive pulmonary disease and diabetes, that the
17 prevalence has increased over the last few years. So the
18 prevalence increase could also increase these numbers.

19 Having given those caveats, what we see here is
20 that of the eight that are shown here five of them did
21 increase fairly significantly between 1995 and 2002. The
22 good news we see, however, is the top one, congestive heart

1 failure, which basically was responsible for 703,000
2 Medicare beneficiaries being admitted to the hospital in
3 2000 has gone down just slightly. It had a 1.0 decrease
4 over that period of time, perhaps due to a better quality
5 provision of ambulatory care. Some of the new evidence that
6 ace inhibitors and beta blockers are effective at preventing
7 admissions for this type of condition, it looks like at
8 least that patients are getting those types of drugs
9 potentially.

10 The top five here, just to note, I guess you can
11 read the slide, are congestive heart failure, pneumonia,
12 COPD, urinary infection, and dehydration.

13 So this indicates that there are some issues with,
14 again, the quality of ambulatory care. And I think it's
15 interesting, I wanted to stop at this point to say something
16 about how what we see here relates to some of the
17 legislative changes. I don't know that the congressional
18 staff were looking at a slide like this, but you can see
19 with their emphasis in the bill on chronic illness
20 management that those are the kinds of programs that could
21 perhaps target some of these conditions, to provide better
22 quality care to patients in the ambulatory setting. For

1 example, if they targeted diabetes, COPD, and CHF, which are
2 often talked about as the good targets for disease
3 management, rates could go down on these admissions.

4 MS. RAPHAEL: For these, did these people have an
5 encounter in the ambulatory system?

6 MS. MILGATE: We don't know. We could probably
7 link some datasets and find out. What we see here are just
8 their admissions, so it's a pretty basic number of what were
9 you admitted for. So we don't know their ambulatory
10 history.

11 MR. HACKBARTH: So this is the total number of
12 admissions. We're just looking at the total number of
13 admissions for CHF, is it going up or is it going down?

14 MS. MILGATE: That's right.

15 MR. HACKBARTH: This is, in any sense, a subset of
16 CHF.

17 MS. MILGATE: That's right.

18 MS. BURKE: I actually was tracking similarly to
19 Carol. Given our discussion about home care, as well as
20 ambulatory care generally, is there anyway to track by
21 matching datasets to what extent we've either seen an
22 increase or a decrease in the treatment for these conditions

1 in the obligatory setting? For example, with respect to
2 home care, is there a way to track whether or not we've seen
3 an uptick or relatively stable number of patients with any
4 of these conditions being treated in a home care setting?
5 The obvious ones are things like dehydration, urinary tract
6 infection, as well as the usual pneumonia and so forth.

7 But it would be interesting to see whether we're
8 seeing a change in behavior in terms of either no care or
9 traditional care, which is less effective, whether the
10 interventions have altered.

11 MS. MILGATE: I'm not sure about the home health
12 example but there certainly are ways to link, through using
13 the beneficiary ID, folks that had admissions as well as how
14 much care. And possibly, through our ACE-PROs, even look at
15 clinically necessary care.

16 MS. BURKE: You mean whether these were people
17 that were essentially being transferred out of nursing
18 homes. It would be interesting to see whether there is a
19 pattern there, in terms of whether they're being treated or
20 not and whether they're essentially coming out of a setting
21 where they should have anticipated these but did not

22 MS. MILGATE: So we can look at admissions and

1 source of admission, for example. Yes.

2 MR. HACKBARTH: It may even be --

3 MS. MILGATE: Well no, I don't know if it's
4 possible by January but certainly is something we could
5 follow up on. And just a note on urinary infection and
6 dehydration, given they are in the top five, it also tells
7 us there may be some important focus there, right?

8 MS. BURKE: Right. The sourcing of where they
9 came from, I think, could make a critical difference in
10 terms of our understanding of how they're being treated,
11 whether they're being transferred on. And watching these
12 patterns generally, in terms of encounters, where they're
13 coming from.

14 MR. HACKBARTH: This is also an interesting time
15 period in that it spans some important changes in payment
16 systems for -- it may even be interesting to look at
17 different time periods within this seven year window.

18 DR. NELSON: That's one set of issues on how to
19 make the data more precise. But there's a more fundamental
20 issuance and that is the use of administrative data which
21 were submitted for a different purpose. They were submitted
22 to get a claim paid. And trying to interpret those data

1 when the reporting is the real issue, not the occurrence of
2 the events. It's whether they were reported or not. And
3 particularly with the patient safety data, extrapolating 95
4 numbers to now or 2000 and trying to draw any conclusion
5 when, as a matter of fact, one of the impacts of the IOM
6 patient safety report would be to increase the amount of
7 reporting.

8 I mean what the IOM said is that the first
9 accomplishment will be if we have errors reported. Henry
10 Krakauer got the IOM going on a series of studies in 1990
11 and whether or not -- how the Medicare claims database could
12 be used to draw some conclusions about quality. Ken Shine
13 chaired those committees. I was on them.

14 And the bottom line was that most of our
15 recommendations called for the PROs to go to the blood
16 records because that was the only way you could really be
17 certain that you were getting accurate data.

18 The use of claims data becomes particularly
19 problematic when you're looking at indicators that are
20 largely subjective such as dehydration. Note that the data
21 are much more aligned if you're looking at a clear objective
22 event like amputation. But is a patient dehydrated or not?

1 If it's reported, is the reporting because they may get more
2 payment if they have a comorbidity including dehydration?

3 I think any of the indicators that are subjective,
4 in terms of A, being identified; and then B, being reported,
5 should be interpreted with more caution.

6 I'd be reluctant to publish these data at all
7 because of the uncertainty about the accuracy. Even the IOM
8 patient safety studies were challenged and they involved
9 duplicative chart audits.

10 MS. BURKE: But wouldn't that be more a case -- I
11 mean, I appreciate what you're saying and there are
12 certainly cases where it could be interpreted in different
13 ways. But it would seem to me that presenting conditions,
14 pneumonia, COPD, urinary tract infections, to what extent
15 are there likely to be errors in judgment about whether or
16 not they were present or not? I mean, dehydration is a
17 variable, but I don't know how you would misrepresent
18 whether someone had a presentation of pneumonia.

19 DR. NELSON: I guess I'd like to have my comment
20 separated in terms of the mortality reports within the
21 hospital, which I think are pretty good, pretty clear cut.

22 MS. BURKE: Straightforward, right.

1 DR. NELSON: And the ambulatory indicators, when
2 you don't have any way to go to the chart and verify what
3 was there, and drawing conclusions. Urinary tract
4 infection, what's a urinary tract infection? Is that
5 cystitis, or is that acute pyelonephritis with something
6 really severe?

7 I guess if we do report this, I'd sure want to
8 have a lot of caveats in there, for the reasons I've said.

9 DR. REISCHAUER: Can I comments on this, because I
10 think Alan's concerns are particularly relevant if we were
11 using this kind of information to say Utah does a better job
12 then Minnesota or this group of hospital does a better job
13 then that group of hospitals.

14 But when you're looking across time at the nation
15 as a whole, these inaccuracies exist. There's no question
16 about them. But the real issue is do they vary tremendously
17 from year to year? And when you see a reduction in one of
18 these measures of 49 percent over a five-year period or
19 something like that, I think you can say with pretty good
20 confidence things are getting better.

21 When you see them about constant, you don't know.
22 But I mean, I think the purpose of this really is to get a

1 broad picture of changes in quality of care for Medicare
2 over the nation and say something sensible about that. I
3 think you're right to look at these numbers and say don't
4 place a bet on the actual number.

5 DR. NELSON: Let me respond to Bob, because I
6 think this a critical point. And the thing that triggered
7 my response is that we have been saying, yesterday and
8 today, that these data show that quality is getting worse.
9 It may be. I'm a firm believer in the quality chasm. I'm
10 not apologizing for the quality of care out there.

11 What I'm saying is that it's hazardous to use
12 these data and infer that quality is getting worse because
13 it may be just that the reporting is getting better. That's
14 all I'm saying.

15 MR. MULLER: Along those themes, part of what
16 puzzles me about this information is that this is a period
17 in which, by and large, admissions per thousand, any kind of
18 numerator, were going down across the board, because there
19 were less admissions per thousand, whether one attributes
20 that to managed care or movement towards outpatient setting,
21 better anesthesia and so forth, but it was a period in which
22 admissions in general were going down. So it's kind of

1 puzzling to me that they would go up on these conditions.

2 That's one point I'd like to have you comment on.

3 MS. MILGATE: These are rates.

4 MR. MULLER: But I'm saying the rates were going
5 down. The rates of hospital admissions were going down in
6 this period.

7 MR. GLASS: These are rates per 10,000 admissions.

8 DR. REISCHAUER: [off microphone.] But these are
9 rates of an event or incident.

10 MR. HACKBARTH: Per 10,000 admissions.

11 MR. MULLER: But if the rates per 10,000 were
12 going down, why would the rates in general --

13 MR. HACKBARTH: So if it went down at the same
14 rate as admissions in general, it would be a zero. So if
15 it's going down faster than admissions -- isn't it?

16 DR. REISCHAUER: [off microphone.] No, it
17 wouldn't.

18 MS. MILGATE: No, it's just how ever many people
19 were admitted, whether it's a higher number or a lower
20 number. It's just a rate of those that were admitted.

21 DR. REISCHAUER: [off microphone.] The argument we
22 would make is that as admissions go down, the severity of

1 the average admission goes up but they're making some kind
2 of adjustment for that, so we don't necessarily have to
3 worry about that. So I don't think there's a problem.

4 MR. MULLER: Wait, we're making an age/sex
5 adjustment, right?

6 MS. MILGATE: These ones? These are age/sex, yes.
7 They're all risk adjusted by different mechanisms so that's
8 why we have to be careful about that.

9 MR. HACKBARTH: Could I get you, Karen, to respond
10 to the issue that Alan has raised? In particular, his
11 concluding point, which I think was a nice concise summary.
12 These are going up because we're looking at them and
13 encouraging people to identify problems.

14 MS. MILGATE: Just a couple of points on that.
15 Alan's point, I think, are particularly important when we
16 looked at the patient safety indicators because I think
17 that's where if you were going to think that hospitals were
18 focusing on a problem that was of high public importance,
19 that's where it would come in. I think that's also the area
20 where the fact that we're relying on administrative data may
21 have more import than the other two indicator sets.

22 A couple of points there. As we discussed the

1 caveats that were necessarily when thinking about using
2 administrative data, one is that I think that Alan's point
3 is very valid if we were talking about any kind of public
4 reported on safety events. I think it would be clear that
5 we would hope and even expect those rates to go up.

6 I feel like it would be less the case if you're
7 talking about simply looking at data that were presented for
8 payment of claims essentially, that hospitals would then
9 code more of these events simply because there was more
10 focus on it.

11 On the other hand, I think there are some other
12 issues with what was going on in coding during those years.
13 One is there was a lot of emphasis on enforcement of fraud
14 and abuse statutes, for example. And so one thing we had
15 thought is perhaps coding became more precise and so these
16 events went up. But on the other hand, there was also sort
17 of a backlash against any kind of upcoding. And these are
18 going to be the coding of the more complicated procedures.

19 So I guess I see there's various forces that would
20 be at play there.

21 The other thing though to check to make sure that
22 we were the right numbers, we did look at and compare our

1 rates to what AHRQ had pulled together on their HCUP
2 database, which is all payer. And then, in fact, CMS has
3 also run these indicators on a Medicare population, a little
4 bit different analysis but not that much, and found that our
5 were very similar in magnitude.

6 Now the HCUP was the all payer, so their rates
7 were somewhat lower. But looking at the trends over time,
8 they went the same direction, up and down. And it was the
9 same thing when we looked at the Medicare data. So it made
10 us feel pretty comfortable at least that everyone was
11 measuring the same way.

12 And in terms of whether we're using administrative
13 data, I guess like we felt like we had some pushes and pulls
14 that led us to feel pretty comfortable with the data.

15 MR. MULLER: I want to go to my public arithmetic
16 here with Bob, because if the rate of admission goes down,
17 which I think is what happened during this period, the
18 overall rate went down, and these rates go up, that's kind
19 of puzzling to me, as to why would the overall rate of
20 admission go down and these ambulatory care sorts of
21 admissions go up. So that's why I'm asking it.

22 If rates are going down of admission, which

1 implies something is going on, whether it's anesthesia or
2 more outpatient care and so forth, yet the rates for these
3 conditions go up, that's a counter movement. So the
4 question is why would you hypothesize they would go up on --

5 MR. GLASS: This isn't the rate per population.
6 This is the rate per admission. So we're saying the rate of
7 people with CHF --

8 DR. REISCHAUER: [off microphone.] Who enter the
9 hospital.

10 MR. GLASS: It's not the number over the general
11 population. It's the number over the number of total
12 hospital admissions.

13 MR. MULLER: So this is the proportion of hospital
14 admissions to which -- okay. That's why I want to do math
15 in public.

16 MS. MILGATE: It does appeared though that these
17 are perhaps a larger percentage of the admissions, even
18 though the admissions have gone down.

19 MR. MULLER: That's what's puzzling to me because
20 you just said we're not tying this to any ambulatory
21 dataset. So it's just --

22 MS. MILGATE: Hospital admissions, number of.

1 It's pretty basic, in terms of that. Yes.

2 MR. MULLER: What's puzzling to me is it's a
3 period in which even prior to the IOM report that Alan
4 referenced, looking at these kind of quality indicators goes
5 back 10 or 12 years and the Joint Commission started pushing
6 this in the late '80s or early '90s.

7 So to hypothesize at a time when people were
8 pushing more to improve quality of care and unevenly, as
9 certainly the IOM reported indicated, and as Alan said.
10 Nobody wants to be an apologist for what the level of care
11 is. But it's puzzling to me at a time when people are
12 focusing on improving care, that the rate of poorer care
13 would go up. It's counterintuitive. So in some sense, the
14 more you push for quality, the worse the outcome?

15 MS. BURKE: But Ralph, let's think individually.
16 Pneumonia could well have been flu. You could see, over the
17 less couple of years, an uptick -- I mean, it would depend
18 on what kind of pneumonia it was. In the case of UTIs or
19 dehydration, it could well be the treatment they were
20 getting in a nursing home. These may not be the fault of a
21 hospital. These may be presented in a hospital setting
22 because of the absence of sufficient care in advance of the

1 admission.

2 So these are potentially avoidable. It doesn't
3 mean that the hospital has given poor care. It may be that
4 the poor care occurred before they ever got to the hospital.

5 MR. MULLER: I understand that and I think they
6 qualified that fairly well. My point is it would be
7 surprising to me to say that the health system in general
8 was having more admissions for avoidable conditions at a
9 time they were trying to focus very imperfectly --

10 MS. BURKE: [off microphone.] The focus was more
11 on the hospital side than it was on the nursing home.

12 MS. MILGATE: We did see the decrease in
13 mortality. The news is not all bad. I think there was some
14 focus from hospitals and physicians that led to that
15 decrease. It may be that that's an easier problem to focus
16 on. I don't know. But we did see some improvement. And
17 the QIO indicators, as well, the process measures that they
18 look at, did improvement. They improved on 20 out of 22 of
19 them, as David reported. So it's not all a bad news story.

20 MR. HACKBARTH: And CHF and asthma certainly were
21 two areas of major focus for the ambulatory and they both
22 got better.

1 DR. NELSON: This list of potentially avoidable
2 admissions, it makes a darn good case for not reducing
3 payments for home care and long-term care for those who
4 subscribe to that theory, that a lot of these -- these are
5 the conditions of people who have run out of gas.

6 MS. BURKE: [off microphone.] That's my point is
7 trying to understand where the admission is coming from.
8 You can track it back to an ambulatory setting or to an
9 inpatient skilled nursing facility.

10 MS. MILGATE: Should we move on?

11 MR. HACKBARTH: Yes.

12 MS. MILGATE: We have one last indicator set to
13 present information on. Sarah will present that.

14 MS. LOWERY: Now we'll look at CAHPS data for
15 Medicare fee-for-service beneficiaries in years 2000 through
16 2002. As you can see, overall beneficiaries highly rate the
17 health care they've received and the quality of their
18 interactions with their doctors and health care providers.
19 On a scale of one to 10, 10 being the highest, over 80
20 percent of beneficiaries gave a rating of eight or higher to
21 their personal doctor or nurse, the specialist that they saw
22 most often in the last six months, and all the health care

1 they had gotten in the last six months.

2 They also highly rate the quality of interactions
3 with their doctor or other health care provider. For
4 example, between 93 and 95 percent of beneficiaries reported
5 that their doctors or other health care providers usually or
6 always listen carefully to them, explain things in a way
7 that they could understand, and showed respect for what they
8 had to day.

9 Beneficiaries seem slightly less satisfied with
10 the amount of time spent with them, but still over 90
11 percent are satisfied with this aspect of their health care.

12 In contrast to these results, we see mixed
13 outcomes when looking at beneficiaries' preventive care and
14 habits. A consistently low percentage of beneficiaries
15 received a flu shot in any of the three years or had ever
16 received a pneumonia shot.

17 However, data on smoking improved over the three
18 years, as you can see. The number of beneficiaries that had
19 been advised to quit smoking by their doctor or other health
20 care provider on at least one visit in the last six months
21 rose substantially over the three years.

22 As you will note in lines four and five, data was

1 not available in a couple of 12 years. This essentially
2 means that the questions asked in all three years are not
3 simply comparable. For example, the question of whether
4 beneficiaries smoked was asked of all beneficiaries in 2000,
5 resulting in a smaller number of smokers than in 2000 and
6 2001, when the question was just asked of those
7 beneficiaries who had smoked at least 100 cigarettes during
8 their life.

9 Finally, of the beneficiaries who were physically
10 able to exercise, this is about 83 percent of beneficiaries
11 since over 16 percent cannot exercise due to their health.
12 So of the 83 percent of beneficiaries who can physically
13 exercise, about half exercise for more than 20 minutes at
14 least three times a week.

15 MS. MILGATE: So what we see here, in summary, is
16 that some indicators are proving, others are worsening. We
17 saw that mortality is improving. It's decreasing as a rate
18 for inpatient mortality, both inpatient measured in the
19 hospital as well as 30 days from admission. We do see,
20 although, some increase in adverse events in inpatient care
21 and some increase in potentially avoidable admissions.

22 However, beneficiaries are very satisfied with the

1 quality of care they are receiving.

2 These data provide useful informational on the
3 quality of inpatient ambulatory care and perhaps suggest
4 some ways that we might be able to think about targeting
5 incentives in the Medicare program. I think we had a pretty
6 good discussion on what we might be able to look at in the
7 ambulatory setting, but it also seems to suggest that for
8 hospitals it might be important to look more closely at
9 patient safety in addition to the type of information that
10 can gathered from the current quality inpatient reporting
11 initiative.

12 At this time, we'd be interested in your comments,
13 in addition to what you've already commented on the data,
14 and questions about the data, as well as what you think
15 these data tell us about Commission work on quality.

16 MS. ROSENBLATT: I think this is a very good
17 introduction to this whole subject and it's nice to finally
18 have some numbers connected with it.

19 I have one question on the stuff from the CAHPS
20 survey. Is there a way to compare the members that we're
21 getting on the Medicare beneficiaries with an under-65
22 population? This isn't very scientific, but my experience

1 in talking to people over 65 is that they're much more
2 willing to view the physician as godlike and it would seem
3 to me that you'd tend to get higher ratings from those over
4 65 data than under 65. That's just my own personal opinion.

5 MS. MILGATE: On these actual questions, I don't
6 know. I've ever seen a survey that has this much detailed
7 questioning of those under 65. There is the National Health
8 Interview Survey which does interview all ages and we do see
9 on that survey consistently that Medicare beneficiaries
10 report much fewer access problems, at least.

11 I'm not aware of a dataset that goes into this
12 much detail on quality.

13 MS. THOMAS: Joe was just telling me that AHRQ put
14 a warehouse together of private plan members reports on
15 their experiences. So we could definitely take a look at
16 that.

17 MS. MILGATE: I'm sorry, it was developed for
18 private sector, excuse me. That's true, we could look at
19 that.

20 MR. HACKBARTH: At Harvard Community Health Plan
21 that was our experience and we had sort of a controlled
22 system so we could look at seniors and younger people in the

1 same clinic, seeing the same physician staff, experiencing
2 the same system of care, and the seniors are consistently
3 rated higher.

4 DR. REISCHAUER: It strikes me that this is an
5 important issue to gather information on. It is conceivable
6 that younger people don't get as good service, but it's also
7 conceivable that their view of authority figures is
8 different. And so what we're going to see over the next 30
9 years is more skeptical people coming into Medicare and
10 these ratings going down. And you don't want to get all
11 worked up thinking that something is changing when it isn't
12 changing.

13 MS. ROSENBLATT: It's also the issue, Bob, I'm
14 hearing from a lot of physicians that the younger patients
15 come in with Internet data and lots of questions and the
16 over-65 population, particularly those over 85, are not
17 doing that.

18 MR. SMITH: As a close cousin of love Durenberger,
19 hate the Senate, I'd be very careful with 93 percent
20 satisfaction rates drawing much of a conclusion from that.
21 It's better than 50, but I wouldn't walk out very far on the
22 road with the CAHPS data.

1 MS. DePARLE: I was just going to say, I know that
2 we did, even three or four years ago, have this kind of
3 ability to compare with some private plan datasets and the
4 phenomenon you're mentioning did seem to be there.

5 In addition, what I remember was that on at least
6 one of them we had the ability to parse between 65 to 70 and
7 then 80 to 90. And the older you get, the more appreciative
8 -- I'm speculating, but it seemed the happier you were and
9 perhaps the more appreciative you are of what you're getting
10 or, as you put it, respectful of authority figures, whoever
11 said that.

12 DR. REISCHAUER: Or maybe those that are satisfied
13 get better treatment so they stay alive.

14 MS. DePARLE: There is some recent data on that
15 actually, that the more satisfied your are the longer you
16 live, the happiness. So hey, I'm there.

17 MS. BURKE: Two questions. One, are you able to
18 separate out the satisfaction with physicians as compared to
19 nurses?

20 MS. MILGATE: They actually asked that question
21 together because they ask if you have a personal or nurse,
22 and then they don't -- actually, they probably could because

1 they do say whether they have a doctor or a nurse.

2 It's a small percentage that say nurse as their
3 primary, but yes, I think we could probably separate that
4 out.

5 MS. BURKE: And the second question, and that this
6 may only be true of pediatrics and I suspect Nancy-Ann has
7 experienced this, as have I. Routinely now, in the series
8 of questions -- and what struck me was the questions about
9 smoking and habits.

10 In the series of questions that are now asked of
11 parents with young children is a question of whether there
12 is a gun in the home. And this is something that is
13 increasing being tracked.

14 I wondered whether -- I mean, it may be an age
15 issue because of the incidence of gunshots in the younger
16 population, but it's actually seen as a preventive issue and
17 intervention. And I wondered whether that was being tracked
18 with an older population or not. It may not be because it
19 may not matter as dramatically, but it is now present in
20 every interview with every pediatrician that I've had any
21 experience with in the last couple of years.

22 I didn't know whether this was true for adults,

1 but it may not be.

2 MS. MILGATE: Not that I know of, but I haven't
3 asked the question.

4 MS. BURKE: It may not be. I suspect it's more
5 peds.

6 MS. DePARLE: We would have been afraid to ask
7 that kind of question, for reasons you can imagine. Because
8 I know on OASIS one of the criticisms was -- Carol will
9 remember this -- we asked about -- and I went through every
10 question after all the controversy over this -- whether
11 there was another person in the home, which is relevant, you
12 clinicians will understand that, for whether there's another
13 caregiver around. That makes a difference in their status.

14 But some people thought we were trying to find --

15 MS. BURKE: Find out what their personal lives
16 were.

17 MS. DePARLE: Yes, you have to be careful about
18 that.

19 DR. NELSON: I think this obviously is an
20 important subject for a chapter. And I think that it ought
21 to include our findings from the administrative database
22 properly qualified.

1 But I think also it ought to include information,
2 if we're trying to set the stage to draw some conclusions
3 for longitudinal assessment of quality, quality assessment
4 over time, then it should include also the findings from the
5 Joint Commission and what they are determining based on
6 their requirements for accreditation.

7 And with particular emphasis on whether things are
8 stable, getting better, or getting worse, where the
9 accomplishments are, where there appears to be areas that
10 still represent substantial deviations from expected
11 quality. Then we can consider this in the context of our
12 job in terms of payment recommendations.

13 But I would think probably NCQA ought to be
14 referenced as well, so that we have a much broader set of
15 data to hang our hat on than just what we've been able to
16 glean from the administrative datasets. And the PROs,
17 obviously the QIOs.

18 DR. WOLTER: Similarly, I was just going to say,
19 along the same lines, I actually think this is quite
20 excellent. And with the caveats that have been brought up,
21 I think it will be quite a contribution to put this together
22 along with some of the other things you mentioned that will

1 be coming forward, the QIO, JCH, some of those other things,
2 because we're still at the beginning of something here.

3 And as we look at this data, the obviously occurs,
4 which is people ask questions. And then they ask questions
5 about how to make the data better. And then that leads to
6 how do we create change? So this will be a great
7 contribution, I think, for MedPAC if we put this information
8 together in one place as others outside of health care begin
9 to look at it.

10 One specific question. Can we cut this by
11 Medicare+Choice fee-for-service and look at those
12 populations separately?

13 MS. MILGATE: The only one -- we could do the
14 CAHPS that way.

15 DR. WOLTER: I meant more specifically.

16 MS. MILGATE: We don't have claims, unfortunately.
17 I guess the comparisons that possibly could be made would be
18 not on these data but looking at some of the fee-for-service
19 rates from the QIO program and some similar measures on
20 HEDIS. So it might be possible to look at those and compare
21 those.

22 DR. WOLTER: It would be nice to think going

1 forward about how we might try to do that, since if we're
2 going to put any quality incentives in place for plans, we
3 might want to have some way to look at that vis-a-vis the
4 things that are being done in the fee-for-service sectors,
5 so there might be some comparability. That might have to be
6 designed going forward.

7 MS. ROSENBLATT: On that issue, wouldn't we have
8 inpatient data from PIP-DCG stuff, and we could at least
9 look at those unavoidable admissions things?

10 MR. GLASS: I don't know if you have complete
11 claims data. It's abbreviated.

12 MS. THOMAS: We can certainly investigate it. You
13 certainly wouldn't have the time trend over those seven
14 years, but we could certainly explore that data.

15 MS. ROSENBLATT: Part of it. When did the PIP-DCG
16 go in, Scott?

17 MS. THOMAS: There was a run up to -- we can
18 explore it.

19 MR. HACKBARTH: Good idea. We'll see what we can
20 do.

21 MS. RAPHAEL: I just was curious if you have any
22 hypotheses. I was struck by your last chart on preventive

1 care. We do flu vaccines in our region and actually the
2 rate of flu vaccines for minority populations is in the 30
3 percent. We've been trying to get that up. But that hasn't
4 moved and the pneumonia vaccine has moved minimally. And
5 yet we saw an increase in admissions for pneumonia.

6 And I'm wondering if you have any hypothesis about
7 why we have not been able to change that.

8 MS. MILGATE: I'd digging back into memories with
9 talking to QIOs about how difficult it is to get pneumonia
10 shot rates up. I don't know, Alan might be better than
11 answering that than I. I don't know. The flu vaccine rate
12 has gone up some, although you see these data here, not on
13 the screen currently. But the CAHPS data don't show it
14 going up as much as the QIO data. So that was kind of
15 curious to me.

16 It may be because beneficiaries are not -- I don't
17 know, you'd think they'd be aware. I don't know. I should
18 just say I don't really know the reason. Alan, do you have
19 any ideas about that?

20 DR. NELSON: I'd have to ask what's happened to
21 the payment rate and whether the is adequate. I don't know
22 the answer to that. In the past it was said not to be but I

1 don't know how much it's been improved.

2 MS. MILGATE: And I know that in the QIO program
3 they had issues because their primary focus was on hospitals
4 and then, of course, there's some reticence to give these
5 types of vaccines within the hospital setting but other than
6 that I don't really know. And I don't know what the payment
7 rates are, either.

8 DR. NELSON: I think they were -- and I should
9 know, but I've forgotten. Last year it cost the physician
10 money for every flu shot they gave. And you can't make that
11 up in bulk volume. I think, as with so many of these
12 preventive services, if you want to have good counseling you
13 have to pay for good counseling. If you want immunizations
14 and preventive services, you can only rely on good
15 intentions up to a certain point. And if they're losing
16 money with it, it's not going to meet the standard we'd
17 like.

18 MR. DURENBERGER: This is probably not so much a
19 clarification as for the final chapter, because I came early
20 and got answers to a bunch of my questions. One of them is
21 the question is what else can be measured by administrative
22 data that we may not have already measured and/or this

1 indication it is impossible to measure adverse events that
2 may have been due to medication errors using administrative
3 data.

4 There's a whole area, it seems -- and I think
5 about the Wall Street Journal article of a week ago as one
6 example. I think about the fact that hospitals get paid to
7 make mistakes and they get paid again several times to
8 correct it, if it takes a couple of times to do it.

9 There's probably a whole body, both in the area of
10 safety and of quality, that can't be accurately measured on
11 administrative data. And it would be helpful if we would
12 not try to answer the question as much as clarify the
13 potential for problems that could exist in this area because
14 they've been reported anecdotally or they're reported in
15 some other context so that the larger picture is
16 demonstrated.

17 And then I think my second observation is relative
18 to the way in which we present the CAHPS information because
19 I read it to say that people think they're getting good
20 quality after we've told them it's not all that great, in
21 effect. And so if it's perception, then I think we ought to
22 highlight perception. That people's perception of quality

1 is sort of a relational perception.

2 I can always see my doctor. I have confidence in
3 my nurse, or in whatever it is. As opposed to something
4 else because it is not the perception that I experience in
5 my work in Minnesota. The folks with whom I work do not
6 find the system that satisfactory.

7 So it's clarifying why we're using that survey
8 data in this chapter that I think is important.

9 MR. HACKBARTH: I think there's also evidence to
10 support the fact that people do distinguish between their
11 doctor and the system. They'll say I like my physician, I
12 have a good relationship. But then if you ask them about
13 the system as a whole, they'll say it stinks. I don't think
14 the two are necessarily inconsistent.

15 Ray, and then we need to move ahead.

16 DR. STOWERS: I'm just going to make a comment on
17 that QIO. Dale Brassard just wrote some recent articles,
18 too, on the distribution of the vaccines. And he's saying
19 that the percentage out there seems to be consistent with
20 the percentage of the patients that are making it through
21 the physician's offices. So that they're not doing that bad
22 of immunizing.

1 So they're saying that we need to broaden the
2 distribution system. So whether it be the health
3 departments or the pharmacies or of the grocery stores or
4 whatever, we've just got to get more exposure to the
5 beneficiaries out there as a place that they can get them
6 while they're out there. Home health care, nursing homes,
7 that kind of thing, that maybe we're limiting the sites
8 where they're giving them more than anything.

9 DR. NELSON: To end up with sort of the good news
10 finding of the meeting. Last meeting, Jack Rowe pointed out
11 it was the marked reduction in admission for stroke, was
12 really the sort of good news surprise.

13 This one, my good news surprise was the reduction
14 of smoking on the last page where it dropped from 24 to 12
15 percent in one year of patients surveyed who said that they
16 smoked cigarettes every day, some days, or not at all.

17 MS. MILGATE: Not to burst your bubble on that
18 being the good news, but in fact those first two years were
19 asked differently than the last, which we discovered just in
20 the last couple of days. And so that's why it's still in
21 your materials.

22 But first years they basically said have you

1 smoked in the past? And then the question was asked of
2 those. So that percentage is probably higher because they
3 smoked in the past.

4 But the last year is of all beneficiaries and the
5 rate is -- I don't know if I could characterize it as low.
6 But it's 12 percent or so. But the doctors advising people
7 to not smoke did go up. That was what I thought you would
8 say the good news was. I thought that was pretty good.

9 DR. NELSON: That's good news.

10 MR. HACKBARTH: Okay, thank you very much. Good
11 work.

12 Next up is ambulatory surgical centers.

13 MR. WINTER: Good morning.

14 I'll be discussing our assessments of payment
15 adequacy for ASC services and our draft recommendation for
16 updating payment rates for 2005.

17 I'll also be discussing ways to revise the ASC
18 payment system AND how CMS decides what procedures to pay
19 for in an ASC.

20 We'll start with the question of whether Medicare
21 payments for ASC services are adequate in 2004. In
22 assessing payment adequacy, one of the factors we generally

1 look it is the relationship of payments to costs. As we've
2 discussed before, however, we lack recent data on the cost
3 of ASC services. CMS was required by statute to perform a
4 survey of ASC costs and charges every five years but it's
5 last survey of ASC costs was in 1994. The Medicare
6 conference agreement eliminated the survey requirement.

7 We'll come back to this issue later on, when we
8 discuss how to revise the ASC payment system.

9 So to assessment payment adequacy ASCs, we
10 examined the four factors listed here. For the first
11 factor, it appears the beneficiaries have good access to
12 ambulatory surgical services. The number of ASCs has
13 significantly expanded over the last several years. In
14 addition, the number of beneficiaries receiving ASC services
15 grew by 14.5 percent per year on average between 1998 and
16 2002.

17 Although ASCs are still not available in all parts
18 of the country, beneficiaries who are unable to access ASCs
19 may obtain surgical services in other settings such as
20 hospital outpatient departments and, in some cases,
21 physician offices.

22 At the October meeting we looked at data on growth

1 in the supply of ASCs. To quickly review, there has been
2 rapid growth in the number of Medicare certified ASCs
3 between 1997 and 2002, which has continued for the first
4 half of 2003.

5 We've also recently examined changes in the
6 average number of operating rooms per ASC, which is one
7 indicator of surgical capacity. This number stayed constant
8 at 2.5 between 1997 and 2002.

9 Industry sources tell us that the majority of ASCs
10 are Medicare certified, however we don't know the specific
11 proportion. An industry survey of ASCs finds that Medicare
12 accounts for about 25 to 30 percent of revenues for a
13 typical ASC.

14 As you requested last time, we are trying to
15 identify ASCs by the types of services in which they
16 specialize, particularly new ones entering the market.
17 However, we've been encountering some problems with the data
18 and don't have this information for today's meeting.

19 The next factor we looked at is changes in the
20 volume of ASC services. Between 1998 and 2002 the volume of
21 services provided by ASCs to beneficiaries increased by over
22 60 percent as the chart shows here. The average annual

1 growth rate during this period was 15 percent. During these
2 years, ASC payment rates increased by less than 1 percent
3 per year, which suggests that the level of payments in 1998
4 was adequate to sustain high-volume growth. Almost all of
5 the increase in ASC volume was due to more beneficiaries
6 receiving services rather than an increase in the number of
7 services per patient.

8 Between 2001 and 2002 the following types of
9 procedures grew fastest: colonoscopy, upper GI endoscopy,
10 and minor musculoskeletal procedures which includes
11 interventional pain management services.

12 There are various factors that could be
13 influencing the growth of ASC services received by
14 beneficiaries but it's difficult to isolate the impact of
15 each factor. First, Medicare payment rates might be more
16 than adequate, particularly given that the current rates are
17 based on 1986 cost data and may reflect productivity gains
18 since then that have reduced costs.

19 Second, there has been a general shift of surgical
20 services from inpatient hospital to ambulatory settings over
21 the last several years. This shift is related to changes in
22 clinical practice and technology which have expanded the use

1 of ambulatory surgical procedures such as colonoscopy and
2 cataract removal.

3 We find that this trend is much more pronounced in
4 ASCs than outpatient departments. Between 1998 and 2002,
5 the volume of ambulatory surgical services provided to
6 Medicare beneficiaries in ASCs grew much faster than the
7 volume of these services in outpatient departments. The
8 average annual growth rate was 15 percent in ASCs as
9 compared to almost 2 percent in outpatient departments.

10 These differences in growth rates may be related
11 to the profitability of Medicare payments or to other
12 factors. For example, ASCs may offer patients more
13 convenient locations than outpatient departments. Medicare
14 coinsurance is often lower in ASCs. ASCs may offer
15 physicians more control over staffing, the surgical
16 environment and scheduling. In addition, physicians can
17 increase their practice revenues by investing in ASCs.

18 Our analysis suggests that ASC's have good access
19 to capital. First, there has been rapid growth in the
20 number of ASCs over the last five years, which suggests that
21 new ASCs are able to obtain capital to begin operations.

22 Most ASCs are independently owned by local

1 investors while some ASCs partner with larger for-profit
2 corporations. Two of the largest ASC chains experienced
3 substantial revenue and earnings growth in 2002 and are
4 expected to continue growing in 2003.

5 In summary, the factors we've examined show that
6 there's rapid market entry by new ASCs, high volume growth
7 in the volume of ASC services provided to Medicare
8 beneficiaries, and sufficient access to capital for
9 providers. This suggests that Medicare payments to ASC are
10 more than adequate to cover current costs.

11 The next part of the update framework is to ask
12 how Medicare payments to ASCs should change for 2005.
13 Several factors could affect the change in the unit cost of
14 ASC services. The first factor is inflation and input
15 prices. The ASC payment system uses the consumer price
16 index for urban consumers to approximate changes in input
17 prices. The CPIU is currently projected to increased by 2.1
18 percent for fiscal year 2005. ASC costs may also increase
19 due to scientific and technological advances that enhance
20 the quality of care but also raise costs. There are certain
21 mechanisms in the ASC payment system that separately account
22 for the cost of some new technologies such as additional

1 payments for new types of intraocular lenses used for
2 cataract surgeries.

3 In addition, high growth in the volume of
4 procedures likely to use new technologies suggest that
5 current payments are adequate to cover their costs. Thus,
6 we do not make an allowance for cost increases due to
7 scientific and technological advances.

8 The final factor that affects ASC costs is
9 productivity growth. As with other sectors, MedPAC's policy
10 standard for expected productivity growth is 0.9 percent.
11 By subtracting productivity growth from input price
12 inflation, it appears that the cost of ASC services will
13 increase by 1.2 percent in the coming year. We believe that
14 current base payments are at least adequate to cover this
15 increase in costs.

16 Thus, our draft update recommendation is that
17 there should be no update to payment rates for ASC services
18 for fiscal year 2005. It is based on our conclusion that
19 current Medicare payments to ASCs are more than adequate to
20 cover current costs and are at least adequate to cover the
21 expected 1.2 percent increase in next year's costs. Because
22 this would reflect current law, there would be no spending

1 implications. We do not believe that this would affect
2 ASC's ability to provide services to beneficiaries.

3 The Medicare conference agreement requires the
4 Secretary to implement a revised ASC payment system, taking
5 into account a GAO study of whether it would be appropriate
6 to use outpatient procedure categories and relative weights
7 for the ASC payment system. The GAO study is supposed to
8 consider data submitted by ASCs.

9 Here we take a closer look at the issues involved
10 in revising the ASC payment system based on the outpatient
11 payment system. ASC procedures are currently placed in one
12 of nine broad payment groups, which makes it difficult to
13 pay accurately for individual services. By contrast, the
14 outpatient payment has over 500 payment groups. The use of
15 a greater number of groups could enhance the accuracy of ASC
16 payments.

17 In addition there is currently significant
18 variation among rates by setting for some high volume
19 surgical services which could create financial incentives to
20 shift service between settings. Using the same grouping of
21 services and relative weights in each setting would likely
22 make the rates more comparable, thus minimizing these

1 incentives.

2 Finally, linking the two systems would allow CMS
3 to update ASC procedure groups and weights each year, along
4 with its annual revisions to the outpatient payment system.

5 This approach does present some concerns, however.
6 The outpatient rates may not reflect the relative costs of
7 individual services which could have a large impact on ASCs
8 that specialize in a narrow range of procedures. If the
9 relative costs of procedures are different in each setting,
10 the outpatient weights may not reflect the relative costs of
11 ASC services.

12 Finally, outpatient departments are eligible to
13 receive certain payments in addition to the base rate such
14 as pass-through payments for new devices, which ASCs do not
15 receive. Outpatient departments, unlike ASCs, are also
16 allowed to bill separately for radiology or imaging services
17 that are ancillary to surgical procedures. On the other
18 hand, ASCs can bill separately for prosthetic devices such
19 as joint implants used in surgical procedures unlike
20 outpatient departments.

21 We propose addressing these issues by recommending
22 that the Secretary revise the ASC payment system based on

1 the outpatient weights and procedure groups but periodically
2 use recent ASC cost data to monitor the adequacy of ASC
3 rates, calibrate the relative weights, and develop a
4 conversion factor that recognizes the lower cost of ASC
5 services compared to outpatient services.

6 We propose not specifying how the Secretary should
7 collect cost data. The main options appear to be through
8 surveys, cost reports, or perhaps by asking groups of
9 experts to estimate the relative levels of resources used
10 for different services. Each of these approaches would have
11 its pros and cons.

12 We expect that a conversion factor based on more
13 recent ASC cost data would result in ASC rates that are
14 lower than outpatient rates for the same service, taking
15 into account additional payments received in either setting.
16 This is based on our finding from the March 2003 report that
17 outpatient departments are probably the higher cost setting
18 for two reasons: they have additional regulatory
19 requirements and they treat patients who are more medically
20 complex.

21 We are currently unable to project the spending
22 implications of this recommendation. Under current law

1 total payments in a revised ASC payment system must be
2 budget neutral to payments under the old system. Our
3 proposal may not result in budget neutrality because we're
4 recommending that the conversion factor should ensure that
5 ASC rates are lower than outpatient department rates. ASC
6 rates that are higher than outpatient rates would decline,
7 while ASC rates that are significantly lower than outpatient
8 rates would probably increase. And it's unclear how these
9 changes would offset each other.

10 In terms of provider implications, ASCs that focus
11 on services that currently receive higher rates in ASCs than
12 outpatient departments, such as some endoscopy procedures,
13 would experience payment reductions. However, ASCs that
14 provide services currently reimbursed at much lower levels
15 in ASCs than outpatient departments, such as some orthopedic
16 procedures, might receive higher payments.

17 We don't expect this recommendation to reduce
18 beneficiaries access to ambulatory surgical services. If
19 some ASCs provide fewer services, beneficiaries could still
20 receive care in outpatient departments.

21 The next issue relates to the list of procedures
22 paid by Medicare in ASCs. CMS is required by statute to

1 maintain a list of procedures eligible for payment by
2 Medicare when performed in an ASC. Procedures must meet
3 several criteria to be placed on the list. They must be
4 performed in inpatient settings at least 20 percent of the
5 time, but cannot be performed in physician offices more than
6 50 percent of the time. A procedure must not exceed 90
7 minutes of surgery or four hours of recovery time and
8 anesthesia must last no longer than 90 minutes.

9 There are also clinical safety criteria. For
10 example, a procedure is excluded if it results in extensive
11 blood loss or involves major invasion of body cavities.

12 CMS is required to update this list every two
13 years. However, the list was not updated between 1995 and
14 March 2003, when it was last expanded. Long gaps between
15 updates make it difficult for the list to keep up with
16 technological changes. They make it possible to perform
17 more services in ASCs.

18 In addition, the volume in other settings may no
19 longer be a relative criterion for determining what services
20 are clinically appropriate to provided in an ASC. In 1998
21 CMS proposed eliminating the time limits criteria and
22 reducing the importance of the site of service volume

1 criteria, but retaining the clinical standards. This
2 proposal has not been implemented.

3 Instead of maintaining a list of services that are
4 eligible for payment, it might make sense for CMS to create
5 a list of services that are specifically excluded from
6 payments. Unless included in such a list, a service could
7 be paid when performed in an ASC. For example, CMS
8 maintains a list of inpatient only services that are
9 excluded from payments in hospital outpatient departments.

10 When considering what services to exclude from ASC
11 payment, CMS should probably continue to apply clinical
12 safety standards and exclude services that are likely to
13 require an overnight hospital stay. To avoid creating
14 financial incentives for services to shift from physician
15 offices to ASCs, CMS might consider excluding procedures
16 that are routinely performed in physician offices and would
17 be paid significantly more in an ASC.

18 We propose recommending that after the ASC payment
19 system is revised, the Congress should authorize CMS to
20 replace the current list of approved ASC procedures with a
21 list of procedures that are specifically excluded from
22 payment based on clinical standards and payment differences

1 between ASCs and physician offices.

2 We propose that this change occur only after CMS
3 has revised the ASC payment system and reduced payment
4 disparities between ASCs and outpatient departments.
5 Otherwise, opening up the ASC list could drive services from
6 outpatient departments to ASCs because of payment
7 differences.

8 This recommendation could increase Medicare
9 spending if more surgical services overall are performed
10 over and above the shifted services from other settings to
11 ASCs. On the other hand, if ASCs are paid less than
12 outpatient departments under a revised payment system,
13 Medicare spending could decline if services shift from
14 outpatient settings to ASCs. ASCs would likely to be able
15 to provide a broader range of services, thus improving
16 beneficiaries access to care. Beneficiaries who could
17 obtain services in an ASC instead of an outpatient
18 department would also likely have lower cost sharing.

19 This concludes my presentation and I look forward
20 to your feedback.

21 MS. DePARLE: I like recommendation three, I
22 think, if I understand it. So what you're proposing is that

1 rather than have the agency try to figure out what is
2 clinically appropriate, allow clinicians to figure that out.
3 And with the exception of some things that are specifically
4 excluded, then things can get more quickly diffused into the
5 ambulatory surgical center setting?

6 MR. WINTER: That's right. That's the idea. The
7 Agency should still continue to look at whether procedures
8 that are being done in outpatient departments are clinically
9 appropriate and safe to perform in an ASC based on the
10 different abilities of each setting.

11 MS. DePARLE: But it makes it a little easier to
12 get things moving. I think that would save them a lot of
13 time, actually.

14 On the second recommendation, I don't quite
15 understand -- well, first you said something about you were
16 having trouble with the data on one of the questions we had
17 asked you to look at. What exactly -- data is the issue
18 here. We haven't had any data. So what are you looking at
19 and what are the problems with the data?

20 MR. WINTER: You and Jack asked me last time to
21 look at what kinds of services ASCs are specializing in, try
22 to identify, try to come up with some kind of matrix for

1 identifying ASCs by what they provide.

2 We've been trying to do that linking ASCs to
3 claims data but we've had a lot of problems matching up ASC
4 providers to ASC claims. So that's been the hang up there.
5 We're going to try to work with one of the industry
6 associations and see if they can help us out doing a survey
7 of their own membership, and we're going to continue pushing
8 this Medicare claims data question.

9 But that's what I was referring to.

10 MS. DePARLE: That would only be for Medicare.
11 Part of the question here and I think that what Jack was
12 getting at, if I recall. is that if 75 percent or 70 percent
13 of their revenues, of a typical ASCs revenues, are non-
14 Medicare, the business model is different. What I remember
15 him saying is something different is going on, something
16 different is driving this.

17 You're having a hard time even looking at Medicare
18 claims data. I understand that's hard. But if we're only
19 going to know then about Medicare, that really still doesn't
20 tell us as much as I think I'd like to know about this
21 industry as we're trying to make these recommendations.

22 MR. WINTER: There is an industry survey that does

1 classify ASCs by whether they provide a certain service or
2 not. So they find that about half of ASCs provide
3 ophthalmology, 45 percent plastic surgery, 40 percent GI.
4 What they don't say is what percent of their volume these
5 services account for, so it's hard to say what they
6 specialize in. But we are going to try to work with the
7 industry some more and figure out if there's a way we can
8 develop a typology.

9 MS. DePARLE: On the second recommendation, how
10 does it relate to the GAO study that is being required?
11 Would we be recommending that the Secretary move ahead
12 without that study? Or how do the two relate to each other?

13 MR. WINTER: That's a good point. The intention
14 here is that subject to the GAO's recommendations, the
15 Secretary should go ahead and do this. But it's an
16 opportunity right now for the Commission to lay down its
17 market in terms of what it thinks a new ASC system should
18 look like, whether it should be designed along the lines of
19 the current outpatient payment system or something
20 different.

21 Because the GAO report is due January 2005, which
22 would be before the March report after this one. So the

1 March 2004 report would be the next opportunity.

2 MS. DePARLE: You're concerned that might be too
3 late.

4 MR. WINTER: If we wait until March 2005, it might
5 be too late. We could do something in June 2004 as well, if
6 you want to spend more time thinking about it and studying
7 it.

8 MS. DePARLE: The GAO, are they just looking at
9 the feasibility of doing a payment system that's based on
10 the outpatient payment system?

11 MR. WINTER: My understanding is that they're
12 supposed to use data submitted by ASCs and other factors, as
13 well, to look at whether it's appropriate to apply the
14 outpatient weights and procedure groups to the ASC system
15 and then make recommendations as to whether that should be
16 implemented or not.

17 MS. DePARLE: So we would be answering that
18 question. We would be saying, in this recommendation, that
19 it is appropriate.

20 MR. HACKBARTH: Is GAO looking at the relative
21 cost issue, both the conversion factor and the relative
22 weights, as opposed to analyzing whether it's appropriate to

1 have a similar system for ASCs versus outpatient
2 departments?

3 MR. WINTER: The legislation does not specifically
4 say they're supposed to look at the relative costs of an ASC
5 procedure versus an outpatient procedure but only the
6 relatives within each setting. Of course, they may decide
7 to go ahead and do that once they have --

8 MS. DePARLE: Somebody has to look at that because
9 we're never going to get anywhere. That's part of the
10 problem.

11 MR. HACKBARTH: My question didn't come out
12 clearly. Let me try again.

13 Is the mandate to GAO, does it assume that we're
14 talking about a system that links payment for ASCs and
15 hospital outpatient departments? So we're looking at that
16 sort of architecture.

17 Now the questions that we need to answer are
18 questions about costs and we need data, GAO please go
19 collect that data. So the premise is that the architecture
20 is some sort of a linked system, a synchronization of
21 payment for ASCs and hospital outpatient departments is the
22 premise, I think, isn't it?

1 MR. WINTER: The question GAO is supposed to
2 answer is whether that process is appropriate. They're
3 supposed to take a look at whether that's appropriate. But
4 you're correct, what we'd be saying here is that we think,
5 in general terms, this framework is appropriate. We do
6 think that the Secretary should periodically collect ASC
7 cost data and make sure that it's appropriate and make some
8 minor adjustments if necessary.

9 MS. DePARLE: I guess, just to be clear, is GAO in
10 collecting the data from the ASCs going to get some data
11 about cost? Because the problem I have with our
12 recommendation -- and Glenn knows I have this problem -- I
13 don't have a problem with assuming that the architecture
14 should be similar. That's what we proposed in '98
15 originally. We did not have the data to do the work
16 necessary to set up those two systems, so we didn't move
17 forward. And we haven't moved forward now in six years.

18 So I object to our presuming lower costs without
19 any data.

20 MR. HACKBARTH: I don't think that's what this
21 recommendation does, at least as I read it. It assumes the
22 same architecture is the way to go, and I do believe that.

1 MS. DePARLE: [off microphone.] And I don't
2 disagree with that.

3 MR. HACKBARTH: But it says that there ought to be
4 data collected to look at the issue of how to set the
5 conversion factor and whether the relative weights ought to
6 be adjusted.

7 MS. DePARLE: But our recommendation says develop
8 a conversion factor that recognizes the lower cost. And I
9 don't think I have the data to say that.

10 DR. MILLER: I think your comment is fair and I'll
11 take responsibility for this. I think in our recommendation
12 the point that we wanted to recognize is that our analysis
13 had generally driven us in this direction. And I think the
14 marker we were trying to lay down in talking about the
15 recognition is an expectation that we will find that. And
16 if that's not the case, then the cost data will show that
17 and then we would recognize it on the basis of the cost
18 data.

19 But our data to this point suggests that it is, in
20 fact, lower. And what we wanted to be clear about is that
21 we're not accepting a budget neutral or higher, because if
22 the payment system right now is driving payments through

1 that results in them being paid more than OPDs, we didn't
2 want to particularly err on that side of saying well, then
3 that's just the way it needs to be.

4 So we're trying to set a marker that our
5 expectation is based on our analysis to this point, that is
6 likely to be lower. It may not have done that well in this
7 language, but that's what the intention was.

8 MS. DePARLE: But isn't our analysis a little
9 speculative? They don't have certain regulatory
10 requirements.

11 DR. MILLER: Absolutely.

12 MS. DePARLE: So it's not qualitatively the kind
13 of analysis that we've done on other things. That's the
14 point I've made.

15 DR. MILLER: That's why, in this recommendation,
16 we are adamant on this point that the data on the cost needs
17 to be collected. So ultimately you can calibrate on the
18 weights and answer definitively the question on the
19 conversion factor.

20 DR. REISCHAUER: Let me see if I have this right.
21 We're willing to recognize lower costs where they're lower
22 but not higher costs where they're higher, based on the

1 recommendation we made last year.

2 MS. DePARLE: Whatever the costs are, they are.
3 Some of them are higher, some of them are lower. If we're
4 going to align it, it should be fair and they should be
5 aligned. So in some cases they should go up. In some cases
6 they should go down.

7 That's another issue, is this budget neutral or
8 not?

9 DR. REISCHAUER: That's a question because I
10 thought we were saying it's good to encourage this sector to
11 the extent that it can provide the service at the same cost
12 or lower. But because there are social externalities that
13 we think are negative in the movement of services from OPDs
14 to surgical centers, we're a little leery about paying them
15 whatever their costs in instances where their costs are
16 higher.

17 Now maybe I'm wrong, but I think that was the
18 tendency.

19 MS. DePARLE: That's what the Commission said last
20 year.

21 DR. REISCHAUER: That's what we said last year.
22 But if that's the case, than the sentence here in this

1 recommendation should say factors that recognize the
2 relative cost of ASC services where lower rather than lower
3 cost, which is what you were objecting to, which sounds like
4 a presumption that always their costs are lower.

5 DR. MILLER: I think, if we're all talking to each
6 other, we're agreeing at this point because I want to be
7 clear that when you attach it to the OPD system, if that on
8 a relative basis moves services around, it would move
9 services around. The question is sort of the overall
10 conclusion about why would their costs, in general, be
11 higher.

12 MS. DePARLE: I would have been in favor of
13 parity, not only saying only where lower.

14 DR. REISCHAUER: I wanted to ask Ariel a couple of
15 things. One is do we know why the requirement for
16 collecting cost data was taken out in this latest
17 legislation?

18 MR. WINTER: My guess is because Congress might
19 have been a little frustrated that -- either frustrated with
20 the Agency for not redoing the survey since '94 or
21 understanding that the Agency had limited resources and
22 didn't have the ability to redo the survey.

1 And also reflecting the notion that if you move
2 towards linking the two payment systems, then you may not
3 need cost data because you just update the weights and the
4 procedure groups based on how you do it on the outpatient
5 side. So that you no longer need to worry about -- my guess
6 is this is the thinking -- you no longer need to worry about
7 what the relative costs are for ASC services, because you
8 collect data on relative costs for outpatient services. You
9 just calibrate the relative weights at the same time.

10 DR. REISCHAUER: The first couple of those reasons
11 you gave strike me as, in a way, outrageous. You haven't
12 done what we've asked you do. Therefore, I'll punish you by
13 not asking you to do it. The limited capability of the
14 Agency, I would have thought, although I'm terribly naive on
15 these kinds of things, that a chunk of money transferred to
16 Price Waterhouse or something could get you an answer here.
17 This is the kind of thing that accounting firms do all the
18 time.

19 MR. HACKBARTH: They shifted it over to GAO. They
20 said CMS has not done it and so we're going to ask GAO to do
21 it. Presumably, they think GAO will be more responsive.

22 DR. REISCHAUER: I do, too.

1 One of the things that interests me about this
2 whole sector is the question of whether the services being
3 provided are primarily substitutes for outpatient services
4 or supplements to. I was wondering if -- this is not for
5 this particular chapter, but over the long run we might want
6 to try and answer that question by looking at the four or
7 five states that have concentrations of these entities and
8 looking at for the Medicare heavy procedures the incidence
9 of those procedures within those states as opposed to the
10 states that don't have many ASCs is significantly higher.

11 And then to ask the question, does this result in
12 improved outcomes, I mean better health? Or do we think
13 that this is another sign of overutilization? Because in
14 the long run that's the kind of question we should be asking
15 it strikes me.

16 MR. WINTER: We have an analysis like that
17 underway. We're going to be looking at ASC penetration in
18 various markets and whether that's associated with an
19 overall higher level of use of surgical services. And I
20 like your idea of trying to relate it to outcomes. We'll
21 think some more about how to do that.

22 MR. MULLER: I want to support the general sense

1 here that having a payment system that has more than nine
2 categories and more like 500 makes a lot of sense and move
3 in that direction, which I think we were moving towards last
4 year and you're recommending here is good.

5 I feel like Bob, that we need a conversion factor
6 and obviously getting that after many years of trying to get
7 it, and just reflecting Glenn's conversation, we really need
8 that.

9 I also think, similar to the conversation we had
10 yesterday on dialysis centers. These ASCs, being more
11 focused, do allow the notions of whether productivity can be
12 achieved in this sector. We had some extended conversation
13 about this yesterday, to really be tested because they see a
14 far more narrow set of patients and conditions and so forth.

15 So a sense in which what the productivity factor
16 in health care might be, as opposed to the kind of general
17 multifactor productivity factor we use, I think could be
18 tested quite well in a couple of settings like ASCs,
19 dialysis, and so forth, where you don't have all the range
20 of the hundreds of type of DRGs and APCs coming in that you
21 see in the outpatient setting of hospitals. And also you
22 have a different regulatory environment. They're not 24/7,

1 and so forth.

2 So I think testing the productivity assumption in
3 this arena would be a good way for us to look, in addition
4 to Bob's question of substitution versus supplement. Which
5 obviously, if it happens in five states -- I mean, in some
6 ways if it's happening in five states more than in 50, you
7 start asking yourself is it medicine or something else
8 that's driving this kind of movement, because if it was
9 happening everywhere to the same extent, understanding at
10 the same time that there are regulatory restrictions in many
11 of the Northeast states that keep this from occurring to the
12 same extent that it happens in the states were, in fact, it
13 did happen.

14 But if we could really focus on the productivity
15 analysis over the course of the next X years, I think that
16 would be very helpful in this setting.

17 DR. STOWERS: I wanted to shift gears just a
18 little bit. I appreciated your mentioning the lower
19 coinsurance. Even if a physician is not involved in the
20 ambulatory surgery center and they're getting ready to refer
21 a patient, and especially if the patient has limited
22 resources, it can make a big difference, at least in my

1 experience, on the financial possibility of the patient that
2 they're facing with an upcoming procedure as to whether I
3 refer them to a physician that's going to do this procedure
4 in an ambulatory surgery center as opposed to the hospital.

5 So I really appreciated you putting that in here.
6 I'm just wondering if we couldn't quantify that for some of
7 the more common procedures, as to what the difference is and
8 financial responsibility to the patient of whether they go
9 to the hospital or whether they go to an ambulatory surgery
10 center. I think that wouldn't be that difficult to do.

11 And I know one comes out of one pot of money and
12 one comes out of the other, but I wonder just how
13 complicated it would be to say we're going to apply this set
14 of copay rules -- could we get the copay rules the same for
15 both somehow? And I know that might be a regulatory
16 impossibility, but it may very well be worth looking into.
17 Because no matter how we level this playing field on this
18 end of the deal, if we don't level the playing field on the
19 incentive of where the patients are being sent, We've only
20 accomplished half of our goal there.

21 So I'd like to see that expanded, so I appreciated
22 you bringing that up.

1 MR. HACKBARTH: Any others?

2 MS. DePARLE: Bob raises, and I'm still not clear,
3 so our draft recommendation to, the Congress has in the
4 Medicare bill said that the Secretary should develop a new
5 payment systems that is budget neutral relative to what the
6 projected spending for ASCs were. Our recommendation is not
7 budget neutral? Or is it? I can't tell for sure.

8 MR. WINTER: It may not be. It depends on -- what
9 they're saying is the conversion factor is based on what
10 would equate payments under the old system to payments under
11 the new system. We're saying the conversion factor should
12 be linked to actual cost data and reflect lower cost of ASCs
13 services where that's shown to be true, based on our
14 discussion today.

15 So that may end up leading to higher overall ASC
16 payments or lower overall ASC payments. It's hard to tell
17 because about one-third of the payments right now are for
18 services in which the ASC rate is the higher than the
19 outpatient rate, and two-thirds are the reverse. So it's
20 just hard to say how that's going to end up coming out once
21 you implement outpatient weights.

22 MS. DePARLE: So like the cataract, I remember on

1 that chart you showed us last year, the cataract procedure
2 where it was paid more in the outpatient setting, for
3 example, right?

4 MR. WINTER: That's right.

5 MS. DePARLE: So two-thirds of the procedures are
6 paid more, then this recommendation could lead to higher
7 spending?

8 MR. WINTER: It could if you end up -- it depends
9 on how much you raise those rates versus how much you lower
10 the ones that are currently higher than the outpatient
11 setting.

12 MR. SMITH: Which raises the question of whether
13 or not we want to or have an obligation to reiterate our
14 earlier recommendation, which is that ASC rates ought to be
15 lower when they're lower and not exist when they're higher.
16 Bob said it more elegantly than I did.

17 But partly because we've got some budgetary
18 consent here and partly because we have some institutional
19 concerns, that migrating services to higher cost settings is
20 not in our interest, not in the program's interest. We said
21 that before.

22 It would seem to me that if we're going to go down

1 the road of the wording in recommendation two, once we clear
2 up what we mean by lower costs, it seems to me we have an
3 obligation to reiterate the earlier recommendation that ASC
4 costs be recognized when they are lower but not when they're
5 higher, or the ASC rates be recalibrated when they're lower
6 but not when they're higher.

7 MR. HACKBARTH: I'd personally be happy to see
8 that happen. But even if that is the case, you could still
9 have an increase in spending because some of the cases where
10 the ASC rates are lower, they could move up based on the
11 cost data. But you'd still have that upward limit for any
12 given procedure we're not going to pay more for an ASC.

13 MR. SMITH: [off microphone.] And we would
14 presume budget neutrality.

15 MR. HACKBARTH: Right. So when we come back with
16 a recommendation in January, it will include that element in
17 it.

18 Anybody else on ASCs? Okay, thanks, Ariel.

19 The last item is SNFs.

20 DR. SEAGRAVE: Last but not least, I will discuss
21 payment adequacy and updating payments for the skilled
22 nursing facility sector.

1 As you know, in our March report, we will make an
2 update recommendation for SNF payment rates for fiscal year
3 2005. In this presentation, I will discuss the steps that
4 we used to come up with our draft recommendations for the
5 coming year in this sector.

6 As you know, current law calls for an annual
7 update to SNF payment rates equal to the full market basket
8 increase which is currently forecast for fiscal year 2005 at
9 2.8 percent. This number may, of course, change as the year
10 progresses.

11 As we've discussed before, freestanding SNFs,
12 those SNFs located in nursing homes, make up about 90
13 percent of all SNFs. For this reason, we focus much of our
14 attention on the nursing home industry.

15 This graph identifies the sources of funding for
16 the nursing home industry in 2001. As you can see, the
17 largest funding source was Medicaid followed by beneficiary
18 out-of-pocket spending and Medicare.

19 On the next four slides, I will briefly summarize
20 market factor evidence we have for the SNF sector this year.
21 Since you've seen most of this before, I will not going into
22 much detail, but I'm happy to answer your questions.

1 Regarding beneficiary access to care, the evidence
2 we have suggests that the majority of Medicare beneficiaries
3 have no problem accessing SNF services but that certain
4 types of patients with special needs, such as those who have
5 diabetes, need ventilator support, are morbidly obese, or
6 have special feeding requirements may stay in the hospital
7 setting longer before they go to a SNF. We don't know if
8 this is a good or bad outcome for these patients but this
9 finding may point to problems with the distribution of
10 payments in the SNF payment system. I'll return to this
11 point later.

12 Regarding supply, the overall supply of Medicare
13 certified SNF facilities and SNF beds appears to have
14 reasonably stable since the adoption of the SNF PPS. As you
15 can see from this graph, the number of Medicare freestanding
16 SNFs has grown pretty steadily since 1992. The number of
17 hospital-based SNFs peaked in 1998 and has declined each
18 year since then. From 2002 to 2003, the number of Medicare-
19 certified freestanding SNFs grew by about 2 percent and the
20 number of hospital-based SNFs declined by 9 percent, with
21 hospital-based SNFs returning to approximately the number
22 seen in 1993.

1 Just a note about this slide, we do not include
2 Medicaid-only SNFs in these numbers because they're not
3 relevant to this discussion. However their members have
4 been declining since 1998.

5 Analysis of the supply of SNF beds nationwide
6 indicates a similar pattern with the average number of
7 freestanding SNF beds increasing and the average number of
8 hospital-based SNF beds decreasing. Not surprisingly we
9 find evidence that freestanding SNF beds often substitute
10 for hospital-based beds in areas where hospital-based SNFs
11 closed. Overall, in terms of supply, we don't find declines
12 in the availability of SNF beds for Medicare beneficiaries.

13 Regarding volume of services, volume grew in 2001,
14 the most recent year for which we have data. with discharges
15 increasing by 6 percent, covered days increasing 8 percent,
16 and the average length of stay increasing by about 2
17 percent.

18 Regarding quality of care, the evidence is mixed.
19 Studies focusing solely on Medicare beneficiaries tend to
20 find no major changes in quality of care since the SNF PPS.
21 However, a small group of recent studies have found declines
22 in quality among mostly non-Medicare nursing home residents

1 since the SNF PPS. But it is still unclear how these
2 results translate to quality for Medicare beneficiaries.

3 Overall we find little evidence to suggest that
4 SNF quality for Medicare beneficiaries has declined in
5 recent years, but it will be important to continue
6 monitoring this area.

7 Now turning to access to capital. The evidence on
8 access to capital is similarly mixed. On the one hand,
9 CMS's annual analysis of the nursing home industry suggests
10 that access to capital has worsened since 2002, due in part
11 to uncertainties surrounding Medicare and Medicaid payment
12 rates.

13 On the other hand, nursing homes' Medicaid funding
14 situation for this year at least does not appear to be as
15 bad as analysts initially had predicted. Recent reports by
16 both the Kaiser Commission and GAO suggest that Medicaid
17 nursing home rates remained relatively stable in 2004. Both
18 sources allude to possible changes down the road if states
19 budget crises continue and worsen.

20 We also find evidence, by the way, that some for-
21 profit SNF stock prices have risen substantially over the
22 past year.

1 And finally, nursing home market analysts
2 generally continue to view Medicare nursing home payments as
3 favorable for the industry.

4 I want to pause here and be clear that I'm not
5 suggesting that the evidence says that overall financial
6 performance in the nursing home industry is just fine, but
7 that the evidence does suggest that Medicare payments are at
8 least adequate in this sector. Of course, this leads to the
9 question then that the Commission has been very clear on
10 about whether Medicare should subsidize other payer sources.

11 In summary, overall the market factor evidence
12 suggests that the majority of Medicare beneficiaries needing
13 SNF services will continue to have access to quality care
14 over the next year. We do remain concerned about the
15 minority of patients who experience delays in accessing
16 care.

17 Now we turn to some of the new information that
18 you haven't seen before. These are preliminary information
19 on freestanding SNFs' Medicare margins. I'm sorry we were
20 not able to bring you margins for hospital-based SNFs today.
21 We had some difficulty with the data. We will, of course,
22 bring these to you in January.

1 The middle column represents the aggregate SNF
2 margin for Medicare payments and costs from SNFs' 2001 cost
3 reports. We have used a very conservative methodology in
4 computing this margin. As you can see, we estimate the
5 margin to be about 19 percent in 2001 for all freestanding
6 SNFs. As in the past, we don't see big differences in
7 margins between urban and rural facilities and, if anything,
8 rural facilities tend to look a little better on most of the
9 margin measures.

10 The far right column contains our projections for
11 SNF Medicare margins for fiscal year 2004. These
12 projections, I want to note, exclude two temporary payment
13 add-ons that were in effect in 2001, but they include the
14 6.26 percent permanent increase to SNF payment rates that
15 took effect in fiscal year 2004. By January, we will also
16 have 2002 cost report data, which may change our projected
17 numbers somewhat. We don't expect them to change
18 significantly.

19 Just a couple of quick notes about the
20 distribution of a freestanding margins. In 2001 about 88
21 percent of Medicare bed days were in freestanding SNFs with
22 positive Medicare margins. As always, there are some

1 variation among types of facilities. For example, we see
2 slightly lower margins in very small facilities with between
3 one and 20 beds, in government-owned facilities, and in very
4 low Medicare share facilities.

5 Overall our margin analysis shows that Medicare
6 payments generally exceed SNFs' costs of caring for Medicare
7 beneficiaries.

8 The last step in forming our draft update
9 recommendations is to consider anticipated cost changes for
10 fiscal year 2005. The best predictor what might be expected
11 to happen to SNF costs in 2005 is what has happened to costs
12 up until now. A number of studies have shown that
13 freestanding SNFs reduced their costs after the SNF PPS,
14 both by negotiating lower prices for contract therapy,
15 substituting lower cost for higher cost labor, decreasing
16 the overall number of therapy staff they employ, and by
17 decreasing the number of minutes of therapy per week they
18 provide.

19 I want to mention along the lines of cost changes,
20 we are aware of one new quality enhancing, cost increasing
21 technology in this sector, the so-called wound vac. The
22 technology may speed healing time and shorten patients

1 length of stay. However, SNFs have little incentive to
2 adopt this technology because they are paid on a per diem
3 basis. We don't expect this technology to increase SNFs'
4 cost much over the next year, in part because they have
5 little incentive to adopt it currently. We might consider
6 ways in the future to incent SNFs to adopt this technology.

7 Next, I present three draft recommendations for
8 your consideration. Our first recommendation, that Congress
9 eliminate the update to SNF payment rates for fiscal year
10 2005. This would mean a decrease in spending relative to
11 current law. Also, since Medicare payments currently exceed
12 costs, we don't anticipate major implications for
13 beneficiaries or for provider's ability to provide services.

14 Our second draft recommendation, even though we
15 find that the current pool of money in the system is likely
16 more than adequate, we continue to see problems with the
17 distribution of moneys in the system as evidenced by the
18 delays certain beneficiaries experience in accessing SNF
19 services. Therefore, we propose recommending again, as we
20 did last year, that the Secretary develop a new
21 classification system for care in SNFs. And that until this
22 happens, Congress give the Secretary the authority to remove

1 some or all of the 6.7 percent add-on currently applied to
2 the rehabilitation RUG groups and reallocate money to the
3 non-rehabilitation RUG groups. We believe this would
4 achieve a better balance of resources among all of the RUG
5 groups.

6 Because this is a redistribution of money in the
7 system, it would likely be spending neutral. However, it
8 could potentially improve beneficiaries access to services,
9 especially for those beneficiaries who currently experience
10 delays in accessing services. And could lead to a more
11 equal distribution of Medicare payments along providers.

12 Finally, our third draft recommendation relates to
13 our efforts to monitor and ensure quality of care in SNFs.
14 Although quality of care in SNFs appears to have been stable
15 in recent years, GAO and others consistently find
16 indications of overall low quality of care in nursing homes.

17 So that MedPAC and others might better study the
18 relationships between nursing costs, total costs, and
19 quality of care, we propose recommending that the Secretary
20 direct SNFs to report nursing costs separately from routine
21 costs on the Medicare cost reports. I want to note that
22 many state Medicaid programs already require nursing homes

1 to break out these costs.

2 This recommendation would have no spending impact.
3 It would likely have no immediate impact on beneficiaries,
4 but it could mean a modest cost for providers.

5 This concludes my presentation. I welcome your
6 questions or comments.

7 MS. RAPHAEL: The area where I guess I had the
8 most concern, and I'm not as sanguine as you are about
9 quality remaining stable, because in the draft chapter I
10 found it hard to differentiate a Medicare patient from a
11 non-Medicare patient because it's sometimes the same
12 patients, although at one point Medicare is paying and then
13 on the next day Medicaid is paying. And you do say the
14 nursing staffing levels have gone down and deficiencies
15 continue to be high. I think the GAO study indicated 25
16 percent rate of deficiencies in nursing homes in the last
17 survey. And then on some of the clinical conditions, like
18 UTI, urinary tract infection, the rates have not shown
19 improvement.

20 So overall, I don't feel that we can say with
21 great comfort that quality has stabilized and is not a cause
22 for concern. I do believe that in nursing homes, to some

1 extent, nurses are a proxy for quality. Nurses and probably
2 CNAs are an important proxy for quality. So I think that I
3 would like to see some changes in how we cast that.

4 I don't know if you've also considered the new
5 feeding assistant which is now permitted in nursing homes,
6 and what we think the implications of that might be.

7 DR. SEAGRAVE: I don't know that we have any data
8 on that yet.

9 MS. RAPHAEL: But I think that is partly in
10 response to a sense of problems in staffing. Whether that's
11 a good thing or a bad thing, I think is subject to future
12 interpretation. But I think that's another example of
13 concern that staffing levels are not what they need to be in
14 nursing homes and that they continue to have shortages and
15 high turnover rates.

16 MR. MULLER: Just a brief question. What
17 percentage of the Medicare patients turn into Medicaid
18 patients?

19 DR. SEAGRAVE: We have relatively old evidence on
20 this. At one point it was thought that about 30 percent do.
21 It may be higher recently.

22 DR. REISCHAUER: I think the right number that we

1 want is what fraction of the Medicaid patients are dual
2 eligibles?

3 MS. BURKE: [off microphone.] Duals are about 12
4 to 14 percent.

5 MS. DePARLE: Overall, but in the nursing homes
6 don't you have a sense it's got to be higher than that? So
7 they're not in there as a Medicare SNF patient per se.

8 DR. SEAGRAVE: We actually are working on
9 developing that number. I don't have it for you yet but we
10 are working on developing that.

11 MR. MULLER: Nancy-Ann, I misunderstand it then.
12 When they first come in they can come in as Medicare and
13 then when the 100 days is -- and then they become Medicaid.

14 MS. DePARLE: Eventually.

15 DR. REISCHAUER: [off microphone.] When we're
16 considering Dave's concerns, we're treating them like
17 Medicaid and somebody else, but we have a responsibility for
18 them in another sense.

19 MR. MULLER: I understand. That's why the
20 distinction -- just following up on Carol's point -- the
21 distinction between Medicaid and Medicare patients, I think,
22 is just a thinner line than we're saying.

1 DR. STOWERS: I'm probably a lone voice on this,
2 but having seen some of our facilities that are really
3 struggling along the way, and full well understanding that
4 we're not trying to substitute the Medicaid payments in some
5 of our states that have gone down, it seems like to me, and
6 knowing that their costs have gone up and their liability
7 costs have gone up, and all sorts of things, that are
8 changed this last year, it seems like to me an update that
9 would at least cover inflation and that kind of thing over
10 the last year, the MEI or minus productivity or something,
11 would at least keep this on some kind of a grade along the
12 way, would keep us supplementing it at the same rate we have
13 been along the way.

14 So it seems like going with no update at all is
15 really backing off, in some way, from what we had been
16 supplementing along the way. So I would think personally
17 that we would give some kind of an update that would at
18 least keep up with their expected increase in expenses.
19 Because what you're showing is that over time their margin
20 is going down. They were at 20 and now they're going down
21 to 14.

22 DR. MILLER: This may not change your point at

1 all, and I need to be clear about this. There was two
2 administrative changes last year. They got the market
3 basket increase last year. And then there was an adjustment
4 in the way the market basket was calculated, that gave an
5 additional 3 percent.

6 DR. SEAGRAVE: Right, it was a market basket
7 forecast error correction for forecast errors that had
8 occurred in 2000 through 2002. So they increased rates by 3
9 percent beginning October 1st.

10 And then they also increased them by an additional
11 3.26 percent for that market basket forecast error
12 correction from 2000 to 2002.

13 DR. MILLER: And that's all reflected in the
14 numbers that you're presenting here, is that right?

15 DR. SEAGRAVE: Right. As I said, the 14 percent
16 number -- it's a little misleading to say that they were at
17 20-something and then went down to 14. The 19 percent
18 margins for 2001, those contained those two temporary
19 payment add-ons. Those are more or less as reported in
20 2001. So they contain those two temporary payment add-ons
21 that, as you know, expired on October 1st of 2002.

22 So the 14 percent, we modeled that according to

1 current law. So that does not contain those two add-ons,
2 but it does contain that 6.26 percent increase that they
3 just got. And that increase is permanently in the rate.

4 DR. STOWERS: As long as our supplement, which I
5 agree we shouldn't be trying to carry the other big load,
6 that this is just not a good time for us to be providing
7 less overall.

8 MS. BURKE: Very briefly, because I'm essentially
9 repeating, in part, what Carol and Ray have both commented
10 on.

11 I am also concerned about the mixed story on the
12 quality issue and indicators that suggest that they are
13 substituting lower cost staff for higher cost staff
14 translates into nursing aides for nurses, which I think in
15 fact has a direct impact ultimately on quality, decreasing
16 the number of therapy staff. I mean, all those, in my view,
17 are not positives. They are, in fact, potentially
18 negatives. The data that we saw in the sort of avoidance,
19 the list of the avoidable admissions, has the smell of some
20 issues occurring in either the nursing home side or the home
21 care side in terms of the treatment of patients.

22 So understanding, if we can, the source of those

1 patients may help us understand more fully what is occurring
2 in nursing homes, and if, in fact, whether it's the
3 pneumonias or the UTIs or whatever it happens to be if we,
4 in fact, are seeing an increase out of the nursing home
5 sector, that to me translates into there are real issues
6 here.

7 So I am also very nervous about presuming that
8 those margins -- I mean, it's Bob's point that there may be
9 enough in the system and the question is whether it's
10 getting to the right places. But I worry about every one of
11 these, decreasing the number of units of therapy, decreasing
12 the number of therapy staff, translating into lower cost
13 staff, or higher cost higher qualified staff, are all things
14 I think that are negatives. And I worry about presuming
15 that all is well and treating it as if we've done the right
16 thing.

17 DR. SEAGRAVE: Yes, and I think that's why I've
18 indicated that the quality evidence is mixed and we are very
19 concerned about the quality. Part of the problem is that
20 under the PPS, when they're getting a prospective rate, the
21 incentives unfortunately are there to reduce the types of
22 staff that you were alluding to and substitute lower cost

1 for higher cost staff and those kinds of things. And those
2 incentives are going to be there no matter what the payment
3 rate is. That's part of the problem.

4 MR. HACKBARTH: I think in both the home health
5 area and the SNF area that's a theme, that there may be some
6 issues of concern about the care. There may be some reason
7 for concern about how the payments are distributed.

8 Then you get to the question well, is higher
9 update factors a solution for these problems?

10 DR. REISCHAUER: I was wondering if we could take
11 a subsample of nursing homes that are highly dependent on
12 Medicare and private pay patients and then ones that are
13 heavily dependent on Medicaid, and look at whether there's
14 substantial differences in staffing patterns, in trends in
15 staffing patterns, in application of therapy, et cetera, et
16 cetera.

17 And then we can determine to what extent this is
18 sort of a fiscal pressure issue as opposed to the way we've
19 chosen to pay these things and the differential incentives.
20 Because it might be a more complex problem.

21 We discovered in the dialysis area that quality
22 and cost didn't seem to be correlated. And it could be that

1 margins and quality aren't correlated here. You'd want to
2 look at that.

3 It's conceivable that we'd come up with some
4 information that then would give some more muscle to Dave's
5 concerns because there's still a lot of Medicare patients in
6 Medicaid dependent nursing homes, and we care about their
7 quality as well as those in the others.

8 DR. MILLER: I know we're able to, and I think you
9 even did subset low Medicare share and looked at the
10 margins. But to the question of whether you can actually
11 look at the staffing ratios, I guess is that something that
12 we even can do?

13 DR. SEAGRAVE: CMS does, on the Nursing Home
14 Compare, they do list staffing ratios. And in fact, they
15 break it down somewhat, I think, by RNs and other types.

16 So to the extent that we can have enough sample
17 size between the two groups that Bob is talking about. I
18 mean, I think we can look at it. It's not going to be super
19 precise, by any stretch of the imagination, but we can maybe
20 do a rough cut.

21 MR. HACKBARTH: Any other questions or comments?

22 DR. NELSON: I think Sheila made a really relevant

1 point and from a physician standpoint oftentimes the
2 question of whether to treatment the pneumonia or the
3 dehydration in the nursing, in the long-term care facility,
4 or transfer the patient to a hospital was based on the
5 question if I leave the patient here and order antibiotics
6 and IVs and so forth, can you do it? Can you handle it?

7 And there's a certain amount of pride on the part
8 of the staff and often, if they can do it they say yes, we
9 can handle that. But if they say well, we only have one RN
10 during the night shift and we just can't be sure that it
11 will get done, then the decision is to transfer the patient.

12 So the clinical decisions are often not absolutely
13 clear cut, and there are alternatives that are viable if the
14 ability of the long-term care facility is adequate to
15 provide what the physician needs.

16 DR. WOLTER: Last year, as I recall, in our
17 recommendations we recommended some type of update for
18 hospital-based SNFs if the reclassification system didn't
19 come to be. And we don't have that margin data to look at
20 this month. I guess we will next month.

21 I'm wondering if draft recommendation two is
22 intended in some way philosophically to deal with that

1 issue?

2 MR. HACKBARTH: Yes, why don't we include that
3 when we come back in January. I don't think that was an
4 intentional omission.

5 DR. MILLER: But it is also true that the second
6 recommendation to reallocate the money is directed at this
7 point.

8 MR. HACKBARTH: Any others? Okay, thank you,
9 Suzanne.

10 We'll now have a brief public comment.

11 MS. SMITH: Since I seem to be the only one
12 between you and you and making your planes, I will be as
13 succinct as possible.

14 My name is Alise Smith, I'm with the American
15 Health Care Association and our major concern, of course, is
16 long-term care and a focus on skilled nursing facilities.

17 I have just a few points and I will run through
18 them as rapidly as possible.

19 First, regarding the forecast error correction.
20 That is what it was, a forecast error correction. And it
21 was CMS saying fundamentally that that money had already
22 been spent by the SNF sector and that the market basket

1 three years in a row did not pick it up because we had
2 estimated market baskets and not actual market baskets and
3 thus we got forecast error correction.

4 Secondly, the issue of the dual eligibles. Well,
5 I don't like doing public math anymore than anyone else, and
6 I hate pulling percentages right off the top of my head. I
7 wish I had a cheat sheet here, but I do believe that a
8 credible figure is 60 percent of the residents of nursing
9 homes are dual eligibles. And I will check on that and
10 provide Susanne with the figure that we have. It is an
11 extremely high figure.

12 Which leads me to a fundamental point. There are
13 6 million, now I just saw a Kaiser figure of 7 million dual
14 eligibles in the United States. And their care impacts
15 obviously heavily in costs on the long-term care sector.

16 There's one interesting point here, regarding Ms.
17 Raphael's comments yesterday on the application problem or
18 the distribution problem in the home health sector.
19 Remember that now there are enormous efforts going out there
20 in the states to shift to home and community-based care.
21 Beneficiaries should be served in the most appropriate site.
22 If it's a nursing home, so be it. If it is home and

1 community-based care, then that care should be efficient,
2 but it should be well funded, monitored, and the labor
3 market and the people who are trained to care for dual
4 eligibles should be there.

5 On the skilled nursing side, we have somewhat of
6 an analogous problem with our population being 60 percent
7 dual eligible. Well, we've been here before with our
8 argument about total margins and we understand your argument
9 about not carrying Medicaid on the back of Medicare, but
10 this cannot be ignored.

11 It's a puzzling fact why the mixture of Medicaid
12 and Medicare has only really historically been broached in
13 the hospital sector with the concept of disproportionate
14 share. Now I don't follow disproportionate share issues and
15 maybe they are somewhat controversial now, but
16 disproportionate share is an add-on, if I'm not wrong, to
17 Medicare. Not to Medicaid, but to account for that high
18 acuity and comorbidities of the Medicare/Medicaid patient.
19 We do not have that, to my knowledge, in home health. We do
20 not have that in the skilled nursing facilities sector.

21 On the issue of taking 6.7 percent and
22 redistricting it down or elsewhere to clinical categories, I

1 think there are so many complex issues that have to be
2 addressed to support such a recommendation. In discussions
3 with Corbin Liu at the Urban Institute, I am impressed with
4 the fact that the issue of trying to determine what the real
5 SNF cost drivers are is an exceedingly complex one. By
6 January 2005, Corbin Liu and his colleagues will have given
7 their best shot at a comprehensive analysis of what drives
8 skilled nursing facility costs and how best then to treat
9 those in a prospective payment system.

10 I will check with someone like Corbin, but I doubt
11 that there's any analysis out there, any data out there, any
12 way possible that CMS, even if they were given authority by
13 Congress, could pick and choose what funds should come out
14 of which categories and to which categories those funds
15 should migrate.

16 In relation to that, I had thought, given prior
17 sessions, that there was going to be a deeper analysis of
18 hospital costs, including cost allocation across hospitals
19 and hospital systems, and the impacts of that allocation on
20 -- well, call them subsidies or entities that are hospital-
21 based -- that's the correct term, -- such as SNFs. I think
22 we should have some further analysis on why those costs are

1 high, if they are indeed higher, and some balance to the
2 argument we hear often that it is all due to acuity, some
3 kind of analysis to balance the acuity argument, which we
4 think needs to happen.

5 Last but not least, and I think I'm picking up on
6 the comment of another commissioner, the issue of stability
7 in these sectors is an extremely important one. Capital
8 access, for example, has been horrendous in the SNF sector.
9 We think it may be improving now, but that is difficult to
10 determine.

11 These sectors, these health care sectors, are very
12 large ships that do not turn very easily on a dime. When
13 you look at issues like beneficiary access or capital
14 access, I am wondering if there could be some deeper
15 explanation of how good is good, how bad is bad, and how can
16 you start to tell when good can turn to bad?

17 What I'm trying to say is that capital access,
18 which he hoped would now be improving, if we lose an update
19 factor, could start back down in the wrong direction. There
20 has to be some horizon, some sense of what might be up there
21 on the horizon, that the decisions that you're making today
22 will impact.

1 I just think it would be helpful if a somewhat
2 deeper explanation could be provided in the final report on
3 these issues of if you do, how you try to determine the
4 cumulative effect of a decision made today and how fast it
5 will affect a sector and what the results might be.

6 At any rate, thank you very much for listening.

7 MR. FENIGER: Randy Feniger with the Federated
8 Ambulatory Surgery Association. I, too, will try to respect
9 your flight times, although I've been in Washington long
10 enough to know that nothing I will ever say will keep either
11 a commissioner or a congressman from missing a plane. So if
12 you need to leave, you will of course probably get up and
13 leave.

14 I want to really address three items quickly. The
15 ASC industry and its relationship to Medicare is poised to
16 change. The Congressional action in the Medicare bill that
17 was just enacted will clearly do that, assuming the
18 Department does its own job, and I assume they will, by 2008
19 we will have a very different system.

20 I was pleased to see that the Commission and its
21 staff have begun to incorporate some of that thinking in
22 their own recommendations that they are presenting to you,

1 because I think that really is where your emphasis ought to
2 be, where are we going, not where have we been. And I think
3 that's where the Commission can make the most valuable
4 contribution over the next months and years is in looking at
5 that change, answering some of the questions that were
6 raised today about relationships between HOPD, ASC costs,
7 services, et cetera.

8 I hope we can get away from the notion or the
9 discussion of the fact that there are a few procedures that
10 paid in the ASC more than they are paid in the hospital
11 outpatient department. We, I think, spend too much time
12 talking about 327 procedures out of the total 2,300 or so
13 that are covered under Medicare. Perhaps what we ought to
14 concentrate on is all of the other procedures that are
15 poorly paid in the ASC compared to the hospital, and the
16 impact that has on patient copays and their out-of-pocket
17 costs because the services are generally not available in
18 the ASC. It might be interesting to look at that.

19 Our industry is frozen until 2009. Hospital
20 outpatient got 4.5 percent this year. There are not frozen.
21 I think any differences in payment, even without changing
22 the payment systems, will vanish while we stay at zero and

1 they keep growing at 4.5 percent or some comparable clip.

2 The migration of services out of the hospital is
3 inevitable. It's happening more rapidly now, it is
4 happening to ASCs, it is moving to physician offices, it is
5 moving to hospitals that specialize in certain kinds of
6 care. I think what the Commission should do in looking at
7 the ASC, and really looking at many other kinds of
8 providers, but particularly ASCs, is think about what is the
9 appropriate place to provide the care? Where can we provide
10 it safely, most effectively, and most cost efficiently,
11 whatever that setting is.

12 I heard some comments that seemed to me to be sort
13 of the hospital as we have known it since the 14th century
14 is entitled to be preserved, ergo we can't possibly change
15 the payment system for ASCs or some other because we'll do
16 some societal harm. Rather than think that way, I think the
17 Commission could profit by looking at what are those
18 services that the community hospital provides best, compared
19 to other settings, and how can we reimburse them, whether it
20 is through private plans or Medicare, your particular
21 bailiwick, in ways that maintain their viability, rather
22 than saying we're not going to innovate, we're not going to

1 allow the transfer or migration of services from one setting
2 to another because we have to protect something.

3 I don't think there is a provider entitlement to
4 Medicare. I think that goes to the patient. I think
5 Medicare ought to look to the best possible use of its
6 dollars.

7 ASCs work for patients and they work for
8 physicians and the staff. The growth that you have seen
9 described to you, I think is a very positive thing. I don't
10 think it's going to stop. It has obviously curtailed to
11 some extent by state regulatory environments, insurance
12 environments in different parts of the country. But this is
13 a model that works very well and I think it is one that the
14 government, and through your advice the Congress, should
15 encourage through appropriate and proper reimbursement,
16 rather than discourage.

17 We look forward to working with the staff and with
18 the Commissioners as we move forward to a new payment
19 system, and we hope that most of your energy will be devoted
20 to that particular effort because we think that your
21 experience can bring great value to that discussion and
22 debate.

1 Thank you.

2 MR. HACKBARTH: Okay, we're finished. Thank you
3 very much and we'll see you in January.

4 [Whereupon, at 11:27 a.m., the meeting was
5 adjourned.]

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