MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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ALICE ROSENBLATT
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DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

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

MR. ASHBY: In this session we are going to use our usual two-step process to develop update recommendations for hospital inpatient and outpatient services for fiscal year '05. But before I begin I wanted to take just a brief moment to acknowledge that while you're going to hear from Chantal and David and I on this project we actually had several other people that contributed substantially here. Tim Greene took the analytical lead on a very complex modeling effort, Craig Lisk brought us the margins we're going to look at, Jeff Stensland did a very useful disaggregation of cost growth, Julian Pettengill helped throughout, as he always does. We pulled in our post-acute team to look at hospital-based services. We pulled in Dan Zabinski to look at per-capita analysis. It was a cast of thousands and we appreciate the efforts of all of them.

Now back to our previously scheduled slide. We considered six factors in assessing payment adequacy, the same save factors that we looked at in the other sectors. We will proceed through them one by one in advance of our draft recommendations.

Beginning with beneficiaries' access to care, we examined two indicators, change in number of providers and the per-capita service use of beneficiaries.

We found no indication that access to care has deteriorated. The chart that we have here shows the number of hospitals participating in Medicare. If you'd look first at the white bars, or yellow on the screen, you see that 636 hospitals converted or opened as critical access hospitals through 2002. Actually that number through October of this year has risen to 835. Certainly that trend has done a great deal to stabilize access to care in rural areas. Then with the dark bars on the left we see that number of hospitals ceasing participation other than through conversion to CAH has dropped each year since 1999, and as of 2002 you'll notice that the number closing is actually equaled by the number opening.

Actually a moment first before we move to volume. Our analysis of per-capita service use in 1999 and 2000 -- unfortunately 2000 is the latest that we have -- shows that overall service usage is holding steady and that rural beneficiaries continue to use services at roughly the same rate as urban beneficiaries.

For volume growth we examined change in the number of discharges and change in length of stay. A large drop in volume might indicate that payments are inadequate, but in fact we found that volume continues to increase. In the first chart here we see that although discharge growth dropped slightly in 2002, the annual rate is still about 3 percent for Medicare and about 2 percent across all payers. The next chart shows the change in length of stay. You can see that the decline in length of stay has slowed until in 2003 length of stay for both Medicare and all payers declined by only 3/10ths of a percent, and that is the smallest decline that we've seen since the late 1980s.

We have quality of care followed by access to capital next and I wanted to turn the mic over to David for those two.

MR. GLASS: Quality of care we see some mixed results. We looked at some indicators developed by AHRQ and that we applied to the Medicare population. From 1995 to 2002 we looked at an in-hospital mortality rates, and for all eight of the indicators we looked at the rates analyzed went down. If we looked at 30-day post-admission mortality rates there was also improvement in six of the indicators. Two of them moved up slightly.

Now what we did see was some deterioration in rates of patients adverse events, or these are called the patient safety indicators. We looked at 13 of those and nine of those 13 rates of adverse events went up over the period from 1995 to 2002. We'll discuss those findings in detail tomorrow.

By another measure, the CMS process measures showed improvement. CMS, through its quality improvement organizations, tracked 22 process indicators and there was improvement in 20 of the 22 for the period 1989-'99 to 2000-2001. You have to use two years of data for those because they're taken from medical records based measures. So quality of care is somewhat mixed.

Access to capital continues adequate. As the slide shows, spending construction is strong, more expansion planned, 80 percent of the non-profits are planning on expanding, debt issuance is increasing. Access varies by financial condition. Poorer performing hospitals are going to face more of a challenge, yet they still seem to be able to obtain capital, though they may have to pay more for it. There has also been use of some less traditional financing such as selling physician office buildings and things like that to raise capital.

We'd also like to note that hospitals in systems, which are over half of the hospitals, have better access to capital than the stand-alone hospitals in general. So access to capital seems to be good.

MR. ASHBY: Turning to the appropriateness of our cost

base, we found unusually high cost growth in both 2001 and 2002. We'll talk in a minute about some of the possible reasons for that high cost growth, but the bottom line is that we find no basis for concluding whether the growth was unnecessarily high, but this obviously is something that we're going to want to watch closely over the next year.

Our chart here shows that the rate of growth in cost per discharge has growth rather dramatically from 0.1 percent in 1997, and that was at the period of time when length of stay was falling rapidly, to 6.6 percent in 2001. Again that's a level that we haven't seen since the 1980s. For 2002, our preliminary value, based on 60 percent reporting, is even higher; 8.1 percent increase in cost per case. But for the 40 percent of late reporters that are yet to come in for 2002 we may have somewhat slower cost growth. We'll talk about the reasons for that in just a moment.

To better understand these large cost increases we disaggregated the extra increment of cost growth in 2001-2002 relative to the year. We found that three factors, labor costs, malpractice costs, and capital costs were responsible for essentially all of the additional growth. Those three factors are shown in their order of importance here.

Starting with growth in labor costs, this was a key factor in both 2001 and 2002. Again, in the order of importance, that is attributable to greater growth in number of employees, greater growth in wages and benefits, and increased use of contract labor. Independent analysis by Peter Burhouse and others strongly suggest that much of the increase in employees, employees and contract labor actually, can be linked specifically to nurses.

They found, using the current population survey, that the number of FTE RNs employed by hospitals increase 7 percent in 2002 alone. The way that we define time periods, that 7 percent actually affects both our 2001 and our 2002 data. Burhouse also suggests that the crisis in nurse employment may already be ebbing, at least temporarily. There are long-term structural factors but for the short term the problem seems to be ebbing.

I would also note that benefits increased even faster than wages, and that maybe due, at least in part, to hospitals being required to add funds to their retirement reserves as the value of their stock holdings fell. But with the stock market improving that should become less of a factor. Then also hospitals, like a lot of other organizations, have seen their employee benefit costs, health benefit costs affected by double-digit premium increases. Wouldn't want to hazard a guess on how long that phenomenon will go on but it was relevant here.

Malpractice costs. These costs increased a startling 35

percent in 2002, although malpractice is actually a very small share of hospital costs. But malpractice premiums are cyclical and we would not expect that level of increase to continue.

Capital costs. These also surged primarily in 2002. It's obviously linked to the renovation and construction boom that David talked about a moment ago. Whether all of the investment that we've been seeing is really necessary is an open question. It's something we really haven't attempted to analyze, but it certainly is a relevant question. We would also point out that capital payments are made prospectively, like operating payments. They are made at a steady rate, so we would really expect the profit margin on capital payments to be somewhat lower at the front end of the capital cycle, and we would correspondingly see higher capital profits years down the line.

Some have suggested that the higher cost growth, particularly the higher labor costs, are essentially making up for the extreme cost pressure the hospitals were under in the last half of the 1990s. Certainly we can cite the fact that smaller length of stay declines have been a factor.

But on the other hand, others have suggested that the willingness of private insurers to grant much larger payment increases in the only 2000's may have fueled excessive cost growth. Yet another possibility is that the measured growth in inpatient cost per case -- we're essentially talking about inpatient here -- may be artificially inflated in recent years by hospitals halting their past practice of allocating as much cost as they could to the outpatient and post-acute care sectors in the cost report since with PPS in those sectors there's really no longer any incentive to do so. We don't have any way at the moment of confirming how big a factor that might be.

Considering all of these factors, we find it quite difficult to determine the appropriateness of cost growth that's more than twice the increase in the hospital marketbasket, or to determine how quickly the industry can return to a more normal pattern of cost growth. But one indication that the unusually high cost growth may already be abating is provided by hospital wage and benefit data from the Bureau of Labor Statistics. Percentages you see in the graph here are four-quarter averages ending in the particular quarter noted. The peak increases of about 5.5 percent midway through 2002 had dropped to almost 4 percent by the end of fiscal 2003. That's when our actual measurement leaves off. The projection is that it will decline somewhat more through 2004.

Turning to our margins, this graph shows the trend in the overall Medicare margin, which we use to assess payment adequacy, and also the Medicare inpatient margin which provides the only available tool that we have to document the upward

trend in margins during the 1990s. In 2001, the overall Medicare margin fell by 8/10ths of a point to 4.3 percent. The inpatient margin dropped a bit more, but that decline was offset by increases in the outpatient and hospital-based home health sectors.

The next slide shows our estimate of the overall Medicare margin for 2002 and our projection to 2004. The 2002 value of 3.2 percent shows a drop of about one point from 2001, obviously reflecting the high rate of inpatient cost growth that we have been discussing here. Our projection accounts for a number of policy changes that occurred between 2002 and 2004, and then also a number of policy changes that the conference agreement has scheduled to go into effect in 2004 or 2005.

So the 2.8 percent figure that we see here represents what the margin would have been, what we think it would be in 2004 if 2005 policy had been in effect. I really need to emphasize though that our projection is preliminary. This has been a rather difficult analysis. We have modeled the effect of 23 different policy changes in coming up with this one number, and that's not even counting updates which are essentially a gimme in the modeling world. So we have a bit of refinement yet to go.

But we will have a final number in January. We don't anticipate that the final number will be much different than what we're looking at here. Then we're also planning to present result of this analysis by hospital group. That will bring some interesting results we think. Among other things, we expect this to document a substantial narrowing of the margins between urban and rural hospitals. In fact we may even be reporting that the aggregate rural margin may exceed the aggregate urban margin when all these provisions are in effect.

Turning to first our inpatient update recommendation, and that will be followed by the update for outpatient. A little bit of context first. The current law increase is marketbasket even, with now a 4/10ths of a percent reduction for any hospital that does not first quality to CMS. CBO reports spending for the inpatient sector in 2003 of $94.5 billion.

Four primary factors govern our draft update recommendation. First is that we conclude that payments are adequate through fiscal year 2004. Although our 2.8 percent current margin is about a point lower than we've reported out the last couple of years, the other factors that we looked at in our update framework don't provide any evidence of inadequate payments. Also, the conference agreement has removed the budget neutrality constraint from our inpatient new technology pass-through payments, and also has liberalized the criteria for technologies to qualify for the pass-through.

Then our second factor is the projected marketbasket increase. That is 3.2 percent. Third, we have our productivity factor of 0.9 percent. Lastly, we have our allowance for cost-increasing technologies of 0.5 percent. We'd like to note here that in future years we may find it appropriate to eliminate this technology allowance if spending for the new tech pass-through payments increases substantially. But we really don't know how that's going to play out. It depends somewhat on how CMS administers the conference agreement provision which has several little details to it, and also the number and the type of applications that come through. So we felt that for this year it's appropriate to leave the technology allowance in place while we monitor the implementation of the new provision in the coming year.

So marketbasket less 0.9 percent plus 0.5 percent produces an update of marketbasket minus 0.4 percent as reflected in our draft recommendation statement here. However, one last point, and that is that we can't be sure about cost growth even for the remainder of the current fiscal year -- we're only two months into fiscal year -- for next year, as we've been talking about here. But the recommendation is for only one year, so we'll have an opportunity to revisit this in another year, and in the meantime to monitor the pattern of cost increases as well as the implementation of this substantial number of complex provisions that will go in from the conference agreement in the next year.

This recommendation would increase spending less than under current law, and given our analysis of the factors today we don't expect any major implications for beneficiaries or providers.

So at this point we'd like to bring Chantal on to talk about the outpatient update recommendation.

DR. WORZALA: Good afternoon. We'll be making an update recommendation for calendar year 2005. Under current law the update would be marketbasket, and the outpatient PPS update was not affected by the current legislation. The Office of the Actuary estimates that spending under the outpatient PPS is $28.6 billion in 2003, about 38 percent of that spending coming from the beneficiaries. The outpatient PPS was implemented in August of 2010 and spending has increased dramatically sine then, rising 9.5 percent between 2001 and 2002, and an estimated 7.5 percent from 2002 to 2003. Growth rates going forward are projected to be 8 percent or so.

As Jack discussed, we consider payment adequacy for the hospital as a whole, mostly due to issues of cost allocations across service lines. Jack went through the major elements of payment adequacy from the framework. I just want to highlight a couple of items specific to outpatient services, including the

share of hospitals providing outpatient services, increases in volume of services, and a quick look at the outpatient margin trend.

First, we've seen an increase over the past decade in the share of hospitals participating in the program that provide outpatient services. We see no change between 2001 and 2002. So the share of hospitals providing outpatient services and emergency services is high; 94 percent and 93 percent, respectively, and 84 percent of hospitals provided outpatient surgery in 2001 and 2002, up from 79 percent in 1991.

In the looking at the volume of services under the outpatient PPS, there's been a very quick increase of 15 percent in the volume of services provided per fee-for-service enrollee. I want to note that this is an increase in the units of service provided, so not in the number of visits. There are a number of explanations for that very high level of growth, some of which are really more data and classification issues. But there is also an underlying real trend in volume growth. Anecdotal evidence and examination of the claims suggests that hospitals improved their coding between these years so they're coding more services in 2002 than 2001, even though they may be providing the same services. So units of drugs and things like that are more accurately coded, leading to the suggestion of greater increase than there might really be.

In addition, the payment system underwent changes in service definition, unbundling some things such as some drugs and blood products. This would also lead to an increase in units because we're now counting those as separate units instead of part of a bundle. But there is at base some real volume growth. We know that in the payments increased 9.5 percent while the update was only 2.3 percent in 2002.

This is a preliminary look at the outpatient margins. We will be coming back with confirmation of these numbers in January as well as some of the distributions by hospital group. These are margins for all outpatient services, although for most hospitals the payments on the cost reports for 2001 and 2002 are 98 percent from the outpatient PPS because payments for non-PPS fee schedule items are reported on different worksheets than those we took our margin payments from.

We see you here a substantial improvement in margins that coincides with the implementation of the outpatient PPS, moving from negative 12.2 in 2002 to negative 6.2 in 2001 and then a drop from 2001 to 2002 to negative 6.7. The 2002 number comes from a sample of 60 percent of the hospitals. For the outpatient margins we did impute values for hospitals where we had a 2001 cost report and not a 2002 cost report.

Some explanation for the trend in the cost reports. There

may, as Jack said, be some shift in the cost allocation back towards the inpatient and away from outpatient. But we do also see payments increasing quickly. According to the Office of the Actuary there was a 16 percent increase from 2000 to 2001 for all outpatient services exclusive of lab, and then 9.5 percent from 2001-2002, 7.5 from 2002 to 2003. 2001 was also a period where the pass-through payments were not capped under the outpatient PPS.

This is also a period where the transitional corridor payments were being made. CMS had estimated that the transitional corridors would raise payments by 4.4 percent across all hospitals although we're seeing -- and I'll talk about this again a little later -- more like 2.3 percent of payments coming from those transitional corridors. But again, that's new money flowing into the outpatient system that would lead to improvements in the margin. Hospitals may also have been looking to control their outpatient costs in response to uncertainty over how this new payment system would work.

So that was a little bit of amplification of the payment adequacy specific to the outpatient PPS and now we'll turn to the update factors. First, of course, looking at our best estimate of per-unit change in input prices. That's the hospital marketbasket increase. The latest estimate for 2005 is 3.2 percent.

Then when we look at the impact of scientific and technological change we see that there are already mechanisms in place to account for the cost of new technology in the outpatient PPS. We have the new technology APCs which pay for completely new services, and the services are placed in a new tech APC based only on their expected costs. We've seen a growth in the number of HCPC codes that fall into those new tech APCs from 75 services in 2003 to 88 services in 2004. There are an additional four applications under consideration at CMS with applications coming in and being considered on a quarterly basis.

Again, this provision generates a payment for each service and there's no budget neutrality constraint there so it's really increased expenditures. Our analysis of the claims show that in 2001 about 1 percent of payments went to the new technology APCs and in 2002 that rose to 1.5 percent.

The second technology provision are the pass-through payments. Here we're really making an incremental payment for something that is in input to an existing service. This is budget neutral and the bulk of the pass-through payments have moved into the base payment system and now we're really getting new technologies flowing through this pipeline with a much smaller number. In 2004, there are nine device categories and

22 drugs with pass-through status. There are additional applications being received and looked at on a quarterly basis.

One last provision that will affect new technology and add additional money to the payment system is a provision in current legislation that sets a floor under the payment rates for drugs that is tied to AWP. This is not a budget neutral provision and CBO put an increment of $700 million between 2004 and 2005.

So for these three reasons we don't see the need for any kind of allowance for S&TA in the update.

Finally, we look at productivity. Again, the 10-year moving average of multifactor productivity in the economy as a whole is 0.9 percent. This is somewhat of an expectation that really ties productivity in this sector to the productivity of the people who fund the program.

Given these factors we propose the following draft recommendation for your consideration. The Congress should increase payments for the outpatient PPS by the increase in the hospital marketbasket less 0.9 percent for calendar year 2005. This recommendation would lead to a smaller increase in spending than current law, and we anticipate no major implications for beneficiaries and providers from this recommendation.

MR. HACKBARTH: So we still need to talk about the outlier issue for the outpatient. But before we turn to that why don't we address the update factors for inpatient and outpatient? Any questions or comments?

I have one. From my perspective the information, the breakdown of margins by type of hospital is going to be even more important than usual. The reason I say that is from my perspective one might feel very different about a 2.8 percent margin if there's a tight distribution around the average than -- in fact you might feel better about a 2.8 percent margin with a tight distribution around that average than you felt about a 3.9 percent margin with big, fat tails, including a lot of hospitals losing money.

I think directionally at least, one of the things that happened with the reform legislation is that the number of hospitals losing money ought to be significantly reduced, certainly among the rural hospitals which were disproportionally in that group. I think that's consistent with what you said, Jack, about your thinking that the average margin for rural hospitals increased significantly. So I think it's not just the average that we need to focus on but also the distribution around the average, so I look forward to seeing those data.

DR. WOLTER: I guess I'll just express again, one of the concerns I have is in terms of how we look at our margin analysis sector by sector. On the one hand we say that we want to look at each sector and try to look at the information and

make an update recommendation. On the other hand, we say cost allocation issues prevent us from doing that and, therefore, we should look at an overall Medicare margin. Today we heard that maybe the cost allocation decisions are being made in a reverse direction, so I don't know what we should do with that suggestion in terms of the outpatient recommendation versus the inpatient recommendation.

I know we can't fix this in the short run, but I wonder as a commission if we should have a goal of moving to the day when we think the data actually helps us to make the decisions sector by sector, because it is difficult. It troubles me actually to find ourselves making these decisions in such a speculative manner.

The other thing I'm wondering about is if there was a year where the data would suggest that a full marketbasket on inpatient might be indicated this certainly would be it, from what I've just seen in terms of the increase in costs and the margins going down. I'm concerned about that, especially when you pair it with what still looks like a negative 6-plus percent margin on outpatient side.

Related to that, I would say that it was interesting what happened in recent legislation in that the full marketbasket update was at least paired with some reporting of quality data, which again as a commission we've said that we want to support. So I'm wondering if there's anything linking to that that we would want to consider in the terms of quality reporting on the inpatient side.

Those would be the issues I would raise in terms of this information.

MR. HACKBARTH: Do you want to respond to those?

MR. ASHBY: A couple of things I wanted to respond to there. First on the allocation issue. We can at least remind ourselves that our rather old data that we do have on what allocation is doing to the inpatient versus the outpatient margin suggests that the outpatient margin may have been understated by as much 15 percentage points. So while that's not a very precise measurement, I think there's really very little doubt that the real outpatient margin is now in positive territory with the minus 6 that we see on paper. There's still a lot of variation around it that we don't understand very well but I think we can at least say that much with confidence.

MR. HACKBARTH: Is it possible, Jack, as opposed to speculate about that, to systematically try to get a handle on it? I think that's what Nick is asking, can we advance beyond this point to where we'd feel much more confident that we know?

MR. ASHBY: We have a study underway that is designed to shed light on this issue. We will look at the allocation of

cost that the hospital cost accounting systems can provide for us, and then restate our margins and see how they come out. Now again, there's no perfect system here. We can never say the correct margin is whatever, but that will shed some light on the extent to which this allocation problem still exists, whether there's been any turnaround in the allocation. That will come up hopefully in the spring, late spring.

DR. MILLER: Could I just have at a couple things? I think we shouldn't be as strong as the statement of, we're clear at this point that the outpatient margin should be positive at this point. I think we don't know. I think it is a frustrating problem, and it's no fun for us to have to repeatedly have to come in front of the Commission with the data sources that we have and present what we have.

The other thing -- and I hate to be so negative here, but the other thing about this study that we're referring to is we'll have it if hospital systems choose to participate in it. If they don't, then it's not clear to me that we will have it. So we need to be clear when we make these statements, it depends on the participation of hospitals and their willingness to give us cost accounting data to do this. So it's a bit tough.

One last thing I'll say, and you've made this point in the last meeting and we are trying to take it seriously and we are getting something of a push in this direction. There's a couple of provisions -- they're not quite on point to your concern here -- of looking at other data sources that are included in the bill that we have to do now as mandated studies, and it can give us a push in this direction. Because I think in the last meeting you said, at least in principle if we could articulate what kind of information at least and then, are there other sources? We will try to travel down this road. I just don't want to over-promise on this cost allocation study because if the hospitals don't step up we will have nothing.

DR. WOLTER: I think philosophically, if our framework is to cover the cost of an efficient provider sector by sector, that might lead to an agenda where we try to get the data sets that allow us to do that. Now it may not be possible, but it is a little bit frustrating when we are dealing with this blend.

Then back on the allocation or the outpatient side. This is just anecdotal so it's only worth that. But in visiting with my CFO and a number of others I get a fairly strong message that if that was occurring it certainly hasn't been occurring in recent years, and that there may be issued around how hospitals allocate having to do with their fixed costs or their square footage or whatever, but that this really isn't an activity that they feel is very prominent at the moment, for whatever that's worth.

DR. REISCHAUER: Just a couple of questions about the charts. I wasn't clear, Chantal, if you gave us a reason why the margins seemed to plateau at minus 6 from 2001 to 2002. You'd be a lot more comfortable about the story that we've been telling if the pattern was minus 12, minus 8, minus 6, going in a direction and hospitals were slowly adjusting to the real world here. But when it levels off and then Jack says, when you put his set of glasses on he sees plus.

DR. WORZALA: I can talk a little bit about the change from 2001 to 2002. One thing is that the 2002 numbers are from a sample.

DR. REISCHAUER: Are incomplete.

DR. WORZALA: But in addition there were policy changes between 2001 and 2002, so the transitional corridor marginal payment percent was declining from 2001 to 2002. In addition, 2001 is when a lot of excess dollars flowed through the pass-through mechanism and that did not happen in 2002. So there are policy reasons for that.

DR. REISCHAUER: So just to hold their own they would have had to have done -- something else would have had to have been going on.

DR. WORZALA: Right. In addition, as Jack discussed, we did see higher cost growth. He showed the cost growth per case, but these are really the same inputs whether it's inpatient or outpatient. We unfortunately don't have a unit measure for outpatient services on the cost report so we can't do an analogous assessment of cost growth per outpatient encounter or service or something like that. But the nurses are the same -- you're paying them the same whether it's inpatient or outpatient. A lot of the ancillary departments, it's the same inpatient and outpatient, so that cost growth would affect the outpatient as well as the inpatient.

DR. REISCHAUER: On that cost growth, is there any way to ferret out the increasing complexity of the average Medicare discharge? If the simpler things are going into outpatient over time and what remains is a resource-intensive procedures with higher costs.

MR. ASHBY: Right. We have two potential measures, one is our normal case mix index across DRGs. It, I believe, is holding fairly steady. We could measure it with an APR-DRG system which would begin to pick up severity of illness, and we have not done that recently and I really can't comment. But we have not seen with the tool that we do have any significant increase.

However, I even have to caveat that by saying, you never quite know what the case-mix index, the degree to which it is measuring real resource changes or whether we're picking up

coding changes. In recent years the coding emphasis has been downward, if anything, in response to all the inspection that's been going on and the like. So we saw a couple of years of actual declines in the case-mix index but we suspect --

DR. REISCHAUER: That was a couple years ago.

MR. ASHBY: Yes, that was a couple years back. Now it's stabilized and that's the best we know.

MR. MULLER: As we make the projection of the '04 margins, I remember the last couple years the industry groups would say that the costs are rising much more than the marketbasket we're putting in. So for example, the 6.6 you showed today and I think you said it might have been 8.2 percent in '02, so if in fact the costs in '02 or '03 were really going at the 6, 8 percent range, is that what you're doing -- are you assuming that's what you're projecting the costs forward from the '01 based at 6 and 8 percent or are you projecting it forward at the 3 percent range?

MR. ASHBY: We began with a projection for '02 and we did pull in that full cost increase that we talked about here. We used a factor that's a sliver lower than the 8.1 because some of our reporters are actually pushing into '02. But we think that that reflects the full cost increases that were actually happening.

Then for '03 and '04 we do have somewhat of a standard there. We projected forward at marketbasket minus just half of the productivity increase. But that reflected a look at the cost pressures and evidence that some of the cost pressures are beginning to subside. We have evidence in the literature that the big push to hire nurses and other technical personnel is really abating. We saw the graph there that showed the wage increases rather abating. And on capital, as we said, we view that a little differently. We probably will consider to have sizable cost increases as we measure capital expenses, but given the capital cycle it's not clear that that's something that we should be responding to. This is something that will have a cycle to it. We're in the upward part of the cycle, and we will later be in the downward part of the cycle.

So looking at all those things together it seems that a return to cost growth that's in the neighborhood of marketbasket seemed like a realistic possibility. But as we said, we don't really know. I think the best that we can do is look at it today and perhaps return a year from now and season the extent to which this is bearing out.

MR. MULLER: Then if it were a couple sixes again in '03 and '04 versus threes that would be a cumulative another 5, 6 percent which would take the margin not in the projected 2.8 but to negative territory. I'm just doing the arithmetic again,

just Glenn's cautions.

MR. ASHBY: Indeed. After a number of years of that level of cost increase you'd really want to start to take a look at why we're seeing that kind of cost --

MR. MULLER: There's a couple things going on that, obviously hitting all of the American economy that's been -- first of all, a lot of these hospitals are employers so they do pay health insurance premiums for their folks at a 10, 12, 14 percent range. Maybe not the marginal costs but there have been major increases to everybody in terms of pension costs the last few years. There have been major worker's comp increases and so forth. So when you look at the staffing cost, those things really start -- and maybe the nursing costs have slowed down but some of these other costs that are affecting all employers, not just hospitals.

So in fact I would not be surprised at all to see that in fact it has been another couple years of 5, 6 percent, and therefore the likelihood that when we do our updates -- when we show the data two years from now -- because really we were sitting here two years ago saying it's going to be say and the industry was coming in and saying it was six, and I think they were a little closer to the data. My guess is that's true again now. So that probably when we're sitting here two years from now we'll find that the costs went up 5, 6 percent each of the last two years and that the margins are not 2.8 but I think the margins probably are going to be less than 1 percent.

So when we look at adequacy, in some ways that assumption that it's a 3 percent cost increase so dwarfs everything else we discuss here, so by making that assumption, is that assumption is really way off, we can be sitting here with an illusion that it's gone from 3 to 8, but it may have gone from 3-something to 0.5 very quickly based on some very really evidence as to how much the cost have gone up the last few years.

I understand that if the industry is not cooperating as fully as you want in terms of getting this cost data coming forth, then it's hard to -- other than using your marketbasket. But my sense is, in looking at it that we're going to be -- this 6 percent was quite predictable based on what people told us two years ago and it's going to be 5 to 6 percent again for '02 and '03 is pretty clear to me. So we can just put our projections down and see where we are two years from now but it's not going to be 3 percent for those two years that just passed.

MS. BURKE: I have two questions that I'm trying to understand. The first is, in the document on page 6 we reference the number and in fact reflect the tremendous increase in critical access hospitals from 375 to 835 in October of '03. The legislation as I understand it further expands the

definition and increases the bed size. So I would assume ultimately in the report we will speculate to some degree on how large this group is likely to become.

I wonder at some point, Glenn, over time if we ought not look at that. You're increasingly, again, get a larger and larger percentage of the hospitals that are outside of the PPS system. Admittedly relatively small, admittedly compared to some a relatively small impact. But nonetheless, that whole concept of moving large percentages -- I mean, we'll have a suspect somewhere in excess of 1,000 hospitals that will be outside the PPS. At some point that has to have some impact on how we begin to look at this system. I wonder at what point we should comment on that, and certainly in the numbers but also reflect on perhaps this is something that we ought to look at over time as we go forward.

The second question that I have, in the recommendation for the update for hospitals, going back to that, you recommend marketbasket minus 0.4. In the legislation as I understand it, they link a portion of the update to the willingness and the ability of the hospitals to submit quality data. Given what we now know and is reflected in this document with respect to the increase in adverse events that occur in hospitals, some of that may be a function of reporting, better reporting. One wonders if there isn't a bit of that. But I wondered why we didn't pick up, or should we in fact pick up the linkage, begin to tie some kind of willingness or participation in the quality provisions as they relate to how we reimburse.

We have suggested in other aspects of our prior reports the desire, and we do it here around dialysis and a number of other areas, to begin to link, as we can, the legitimacy of a payment to a quality outcome. But this in fact is a data issue. That is, some kind of linkage to the hospital's willingness to report, and whether that isn't something we ought to think about as well. In this case we did a minus 0.4. In the case of the legislation as I understand it, it includes a 0.4 if in fact they are willing and then it minuses a 0.4 if they are unwilling to submit the information. I wonder if we had thought about that or is that --

MR. ASHBY: Actually the way the legislation reads is that it gives the actual update as marketbasket and then says they will be penalized 0.4 off if they don't provide the data. That same feature could be attached to our recommendation.

MR. HACKBARTH: Let's have some discussion about that. That was also one of Nick's points.

My personal initial reaction was, if assessing processing quality is important, as I think it is -- I think it's vital -- why is it optional even with an incentive? Why isn't this a

condition of participation in the program? That was my initial reaction.

Then the second one was, if we say for hospitals we're going to pay in some fashion for the data, does the same hold true for every other class of providers? For the combination of those two reasons I personally wasn't confident that this was a good precedent to set.

MS. BURKE: If I could respond. I recall, and Nancy-Ann will have to correct me -- we have in the past explicitly paid for certain kinds of data. We did it in Medicaid. We've done it in other places where we set a bar and say, we want you to comply with whatever it is, administrative flex -- whatever it happens to be. And we have been willing to incentivize people to move in that direction.

In this case, you're right, a condition of participation ought to suggest that they ought to do whatever it is that they ought to do. The complexity of the data collection and analysis -- I mean, we have added over time increasing burden in terms of what we are expecting facilities to produce, and this is certainly true at smaller units as well. The capacity of a hospital to do it, or any kind of organized system is far greater than it is at smaller units. Physicians' offices, we've admitted we have an enormously difficult time gathering that information and analyzing it on a per-unit basis. Organized systems could increasingly begin to produce it. The hospital though is the most obvious because it has the greatest demand in terms of what it is we expect of them today.

I agree with you, over time it ought to go in the direction where it is what we need, it is expected, do it. But I wonder, given where we are today, given that we've seen clear indication of an increase in adverse events, whether or not we ought to put an emphasis on it in the short term and then move towards it in the long term and maybe say that.

I don't disagree with where you want to get. I just wonder if in the interim we ought not create some kind of strong message that quality increasingly is important and we're willing to try and help you produce that. And maybe over time we do it with the other facilities and the other providers as well.

DR. WOLTER: Just another point on that, because I agree with that and I think a second and third step, whenever it comes around, conditions of participation would be a great place to get to. As I understand what is going to be required in terms of tying in the legislation that payment to reporting it, it's data, but it's specifically reporting of measures being taken, process measures that have been shown to improve quality of care. So it really is linking what's being reported to activities which have been shown in the literature to improve

quality. There's potentially some value in that in these early stages of trying to link payment to quality.

MR. ASHBY: Just one brief comment of the CAH issue. While I think we all believe we could easily be looking at 1,000 CAHs a year or two down the line, we also have to remember though that the equation has changed here. The payments are much more attractive now for small rural hospitals under the provisions of the bill than they were, so I think there will be a lot of rethinking of the right decision here by some CEOs.

DR. WAKEFIELD: I was going to ask you that, Jack, whether or not that wasn't a possibility, that there may well be hospitals that are going to stay put because of those new provisions making that automatically default to a CAH not the better financial option.

MR. HACKBARTH: As I recall, that was basically the stance that we took in our rural report, was rather than have more and more hospitals opt out of PPS, let's fix PPS so it's fairer to rural hospitals and make it a viable opportunity.

MS. BURKE: Jack, you're absolutely right and I wonder if that's part of what we ought to look at in terms of what will happen. But you still have a large -- I mean, there is still proportionally a large number who have already, query whether or not more will because of the expanded definition or whether or not these payment adjustments will in fact satisfy what those needs are. But you have states -- I don't know if this is still true of Kansas, near and dear to my heart, but there was a point in time when Kansas had 50 percent of its hospitals had fewer than 50 beds. You had geographically huge chunks that could move into these systems.

Now this may fix it. It may do exactly what has been proposed. But it seems to be we ought to be watching that to see whether or not it achieves what it intended to achieve, which is to equalize the system.

MR. ASHBY: Absolutely. We have a report coming up on the rural provisions and I think CAH as part of that is absolutely appropriate.

MR. HACKBARTH: Other comments on the paying for data issue?

DR. STOWERS: I was just going to back to what Nick said. I just don't think there's anything wrong at all with the Commission confirming the fact that it's okay to pay for data and to recognize the fact that data cost money to collect and that it's worth paying a little bit of money for that. And for the technology and medical record systems and so forth is a recognized expense in the hospitals. This quality is going to cost some money and that Congress is going to have to step up and help pay for it.

MS. DePARLE: If we're going to pay for that, could we pay for quicker cost report or something that would give us -- seriously. That's been one of our big bones of contention is that the data that we use is always so lagged.

MR. HACKBARTH: I don't know how much of that is a hospital issue as opposed to a CMS issue.

MS. DePARLE: Yes, an intermediaries.

MR. HACKBARTH: Of course we could pay them for more data too.

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 4, 2003
10:13 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.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Hospitals:
Outpatient PPS; outlier and transitional corridor payments -- Chantal Worzala

MR. HACKBARTH: Hearing none, do we need to do the outlier thing now? Is that the next up?

DR. WORZALA: If you have the stomach for it. Switching topics a little bit, we'll talk about two issues under the outpatient PPS, the outlier payments and transitional corridor payments. We discussed the conceptual basis of outlier payments in October. I don't want to go over that here. Briefly, we framed the outlier as a kind of insurance, providing hospitals with financial protection in the event of extraordinarily high costs in comparison to their Medicare payment rates. The ultimate goal of that kind of outlier provision is to protect access to care for beneficiaries that incur extraordinarily high costs.

During this presentation I'll review the outlier policy as it stands today, reiterate our policy questions and present some data inform them. Then I have three recommendation options for you to think about. Again, these are options and I would appreciate your feedback on them.

On the second issue, transitional corridors, I'll update you on the impact of the current legislation very quickly, because we covered that this morning, but then also give data from the cost reports on the importance of these transitional corridor payments for different types of hospitals. I would like your guidance on whether to pursue that particular issue any further.

The outlier policy for the outpatient PPS is required by statute. Like the outlier policy in other settings it must also be budget neutral. Therefore, CMS reduces payments for all APCs to fund the outlier payments. Congress set an upper bound on the outlier payments of 3 percent. CMS has so far targeted outlier payments below that limit. In 2003, the target was 2 percent and that will be maintained in 2004. If actual payments exceed or fall below that target amount, no effort is made to modify the conversion factor to recoup or return over or underpayments.

In 2003, the outpatient PPS provided outlier payments to all APCs except for pass-through drugs and devices. This was regardless of the payment amount for the service and includes both broadly defined APCs such as surgeries, and narrowly defined groups such as an x-ray or an echocardiogram. The recent Medicare legislation will remove separately paid drugs

from receiving outlier payments effective 2004.

CMS estimated that a cost threshold of 2.75 times the payment rate for the APC and a marginal payment factor of 45 percent of the cost above the threshold would result in outlier payments that meet the target of 2 percent. I believe there's a discrepancy between what's in front of you and what's on the screen with the cost threshold. It is 2.75 not 3.5.

How do the fiscal intermediaries calculate the outlier payments? Basically, outlier payments are based on estimated costs since those costs are estimated by the fiscal intermediaries by multiplying current charges on a claim by a cost to charge ratio from the most recent tentatively settled or settled cost report. Even using that most recent tentatively settled cost report generally results in a time lag of one to two years between the calculation of the cost to charge ratio and the submitted charge on the claim. So if the charges have increased at a faster rate than the costs since that cost report period, the CCR will result in an estimate of costs that are higher than the actual costs.

There are, of course, many reasons for a hospital to increase charges faster than costs, and no matter what motivation this pattern would result in unwarranted outlier payments. Since this is a budget neutral system those are paid for by other hospitals. Since the outliers are budget neutral that has distributional effects.

This slide shows the historical relationship between cost and charges since 1985. The metric here is the ratio of cost over charges, so a lower value indicates that charges are higher than costs. This is a CCR on this chart for all patient care service not just outpatient services. But what we're looking for here is the trend over time. You do see a secular trend of charges rising faster than cost among all hospitals. With any of these metrics there can be variations across hospitals. We do know that there were some hospitals that were very aggressive in raising their charges.

So as I mentioned there is this time lag, which means you are overestimating costs if you use an older cost to charge ratio against the current charges on the claim.

CMS has done quite a bit to limited this problem. They have required that the FIs update their CCRs whenever a new cost report is submitted or settled. They give a very short time window for the FIs to do that. And they have changed a provision where if a CCR seems exceptionally low they simply verify that that's the correct CCR rather than substituting a state-wide average CCR. Nevertheless, this problem is inherent in the calculation of outlier payments.

There's an additional issue that arises here because the

FIs are calculating a single hospital-level outpatient-specific cost to charge ratio. We know, however, that the relationship between costs and charges can vary by service depending on the hospital charge structure and how much they mark up one type of service over another. So if one department routinely has a higher markup than the average, the estimated cost for services in that department will be overstated, and those services attract more outlier payments. Then the opposite is true for a department that has a lower markup.

One thinking about this, it's parallel in some way to the coinsurance structure under the outpatient PPS where coinsurance what was based on charges. If you look at the coinsurance rates you see a rate closer to 50 percent for things like imaging, departments where we think the markup is higher versus other services, some of the clinic visits and things where we think that the markup might not be as high. So keep that in mind as I show you some of the service level results in a few minutes.

What are our policy questions that we're trying to address? First, does the outpatient PPS need an outlier policy? Second, if it does, what is the appropriate design?

In October we discussed at some length this first question. I'll quickly summarize the arguments here since some time has elapsed. There are a number of reasons to think that the outpatient PPS does not need an outlier policy. First, there's a very narrow product definition and we have many ancillary services and inputs such as drugs, x-rays, that are paid separately, leading us to think that variability in costs will not be great.

Second, the APCs have low payment rates, which means that the size of the potential loss from any given service is generally quite small even if it's very costly in comparison to the payment rate.

Third, there are some equity issues. This is a budget neutral system so the base payments have been lowered to fund the outliers, and the outliers are not evenly distributed. So there are some distributional effects. In addition, there is potential for outlier payments to be made in response to increases in charges, not necessarily increases in costs. Again, since this is budget neutral it may be more equitable in fact to have no outlier policy.

Finally, the outpatient PPS is the only ambulatory care setting with an outlier policy, but many of the services provided there can be provided in physicians' offices or ASCs, so you're creating on more difference in how we pay for these services across settings, which is a larger payment question.

It despite those no arguments there are some arguments to maintain the outpatient outlier. First, we do see a shift

toward more sophisticated and more costly services moving to the outpatient setting, outpatient bone marrow transplants, outpatient mastectomies, things that are fairly significant procedures, in addition to cardiac catheterization, implant of cardiac devices, those sorts of things.

Second, the outpatient PPS is a fairly new payment system. It's been a little bit difficult for CMS to set the payments given the data that they have available and hospital coding practices and those sorts of things, so the outlier may be providing a cushion for rates that are actually too low. It would be better to fix the payment rates, and I think as the payment system matures there will be less of an issue there. But in the interim, maybe the outlier payment is serving a purpose there.

Third, we do see that there's a potential for distribution of cases across hospitals that is not random. Some hospitals may have more expensive cases on a routine basis and the outliers would help cushion the impact of that for those hospitals.

Moving on to the second set of design questions. Here we're really looking at how, assuming we want to keep an outpatient outlier policy, how would we determine eligibility, how shall we set the threshold, and indeed, how much funding should there be if we change either the eligibility or the threshold? Very quickly, you've seen this slide before. Most APC groups have low payment rates per unit. Two-thirds have payment rates of less than $500 and 75 percent have payment rates of less than $1,000. There are some high-paid services, insertion of a cardiac defibrillator is about $17,000.

Here we look at the services receiving the most outlier payments in 2001. First of all, almost all APCs received at least some outlier payments, but a relatively small number, 26, accounted for 50 percent of the outlier payments. These same services accounted for only 38 percent of the payments. The nine services on this chart -- obviously I couldn't put all 26 on there. The 26 are in your briefing materials. The nine on this chart account for 29 percent of the outlier payments and 25 percent of APC payments.

In looking at this chart we see that the payment rates for all of these services that are the top outlier getters are low, under $400. This first service that received 6.6 percent of the outliers is infusion therapy except chemo. We might expect considerable variation in the cost for this particular service because there are packaged drugs and infusion fluids in the payment rate and that may vary quite a bit by patient. However, CMS is now paying separately for many drugs and there's this floor under drug payment amounts so moving forward we may not

expect as much variability for this APC.

The next two services, the CT and the x-ray seem to have less intuitive rationale for variability in cost and the need for outlier payments. I'm not quite sure what an outlier CT is. One thing that I should say, however, is that these are very common services. So for example, the x-rays, where you see the share of the payments and the share of outliers being the same, random variation could explain that but I think we have a question of whether that the kind of service that we want to protect given that it's a payment rate of $40.

MS. DePARLE: Chantal, can you walk through 0260 level one x-ray $40. What does that mean? How do you qualify for an outlier payment?

DR. WORZALA: You have costs that are -- we'll just say that the threshold is three times, so you have costs that are more than three times the payment rate. So you're reporting costs from your x-ray that are $40 plus $120, $160 and then you qualify for an outlier.

MS. DePARLE: So for an individual patient your costs were 2.75 times the $40?

DR. WORZALA: Correct, and then we're paying a fraction of the cost about that threshold.

MS. DePARLE: Clinically, what would have caused that?

DR. WOLTER: I was just trying to figure out what it might be.

DR. REISCHAUER: Couldn't all of your x-rays fall into the outlier?

DR. WORZALA: Yes, all of your x-rays could fall into the outlier.

DR. REISCHAUER: So it's a hospital that has very high charges for this.

DR. WORZALA: Yes. Let's focus a little bit on --

DR. WOLTER: It probably wouldn't be worth knowing although it may be that at that low a payment rate it just doesn't matter, but you might wonder is it somebody in the emergency room who has a neck injury and getting a c-spine film is very difficult and it takes multiple views. You could imagine some clinical reasons but I honestly don't know.

DR. NELSON: I know you want to move on but while we're on this subject with our hypothetical chest x-ray that goes off the top of the chart, is the patient insulated from -- in their copayment?

DR. WORZALA: Yes. Only the program pays an outlier payment. The beneficiary only pays their copay.

DR. NELSON: So is the patient's copayment higher?

DR. WORZALA: No, it is not.

MS. DePARLE: So the patient's copay is only based on $40?

DR. WORZALA: That's correct. Focusing on the cost to charge ratio, if we look at the electrocardiograms, they receive 3 percent of the outliers and were only responsible for 1 percent of the payments. The table in your briefing materials has another column that looks at outlier payments as a share of outlier plus APC payments. For this particular service, 12 percent of the total flowed through -- 12 percent of total payments for electrocardiograms came from the outlier payments. I think this may be an example of a service that has a higher than average markup.

Moving onto outlier payments by hospital group, we're looking at the distribution of outlier payments among hospitals across three different groupings, location, teaching status, and ownership type. In each group we're seeing that one type of hospital received a greater share of outlier payments compared to APC payments than others. It doesn't, however, tells us why. These relationships could be explained by differences in patient mix, could be explained by differences in cost, it could be explained by differences in charge structures. These numbers are from 2001. We have also just analyzed the 2002 data and we'll bring those results to you in January.

The top right number there of 3.3 percent indicates that in 2001, if you took outliers over the sum of outliers plus APC payments the outliers were 3.3 percent of the total. This is a ratio from the claims. There's no transitional corridors. In 2001, the target was 2.5 percent, so it's slightly higher than the target. However, when we look at the 2002 claims it drops down to closer to 2 percent. So I don't want people to take this away and think there's a major problem. This was 2001. 2002 is closer to 2 percent. However, in both years the patterns across the hospital groups are similar.

One other note, both of these two years precede implementation of some of the steps that CMS has taken to limit gaming, so the CCR calculation -- this involves older CCRs I guess is what I would say.

So let me take your attention to the final column which again is outliers as a percent of all payments. By location, hospitals in large urban areas received 4 percent of all payments from the outlier. For other urban and rural hospitals it was lower, 2.6 or 2.7 percent. If you look at it by teaching status, outlier payments accounted for 5.3 percent of payments to major teaching hospitals. It was lower for the non-teaching groups or the other teaching group. By ownership we see that the for-profit or proprietary hospitals received 5 percent of all payments through the outlier mechanism.

I also did an analysis looking at the distribution of outlier payments as a share of all payments for individual

hospitals. Looking at that we see that 50 percent of hospitals had outliers that were 1 percent or less of total payments, 75 percent had outliers that were 4 percent or less of total payments, and at the other extreme, we had 1 percent of hospitals where outliers represented 30 percent or more of payments. There I only include the hospitals we know from analysis from CMS, but for the community mental health centers it was closer to a one-to-one ratio of outliers to base payments. I also required that the hospitals have at least $1,000 in payments for that analysis.

In summary, since I've shown you a fair amount of data, we know that most outpatient PPS services are narrowly defined and have low payment rates. We've seen from the data that most of the services receiving the greatest share of outlier payments have low payment rates and are narrowly defined. The data also show that the distribution of outlier payments varies by hospital group and individual hospital. These differences could be due to differences in patient mix, cost structure, or differences in charging practices. It's probably a mixture of all three.

Finally, we think that the calculation of the outlier payment makes it susceptible to gaming. Although to be fair CMS has taken some steps to limit those opportunities, but there is still nothing to stop a hospital from taking a commonly-provided service and increasing their charge for that particular service and getting some outlier payments that way.

Given these conclusions I'll present you with -- I'm sorry, there's one other global comment I wanted to make which is that looking at this data I'm not sure it's clear that the outlier policy is really protecting hospitals from large financial losses, at least in the bulk of the outlier payments. Therefore, I'm not sure that it's having a lot of impact on beneficiary access to care. We may not be making outlier payments in cases where patients truly are more costly I think is what I'm saying.

So with that context we have three recommendation options. Again these are options. The first option is you do this and you don't need to do the other two. The other two you could do in some sort of combination.

The first recommendation option would be that the Congress eliminate the outlier provision for the outpatient PPS. The spending implications of this would be nothing. The provision is budget neutral and presumably the funds would go back into the base conversion factor. The impact on beneficiaries and providers, it seems unlikely, given what we've seen, that this would adversely affect beneficiary access to care. But we do know that it would redistribute payments among hospitals when

you shift funds to the base.

Recommendation option two read that the Secretary should introduce a dollar threshold to the outlier policy under the outpatient PPS. The Secretary was given authority to do this under BBRA. The spending implications would be none since it's budget neutral. I would think that this would actually better protect beneficiaries with extraordinary high costs because you could focus the limited funds that are available in the outlier to those that are truly extremely costly. It would probably result or may result in a redistribution of outlier payments among hospitals.

The third option takes a slightly different approach to modifying the outlier policy looking at services as opposed to a dollar threshold and it read that the Congress should give the Secretary the authority to limit the kinds of services eligible for outlier payments under the outpatient PPS. Currently by law all services must be covered unless stated otherwise in law, and we do have this example of the separately paid drugs now not being eligible for outlier payments. Here the spending implications, none; and for beneficiaries and providers would probably better protect beneficiaries with extraordinarily high costs and may result in the redistribution of outlier payments.

MR. HACKBARTH: Questions, comments?

MS. ROSENBLATT: Just a quick comment. I think the chart on page 10, the one that we were all getting excited about leans me towards recommendation number three, because if I look at 0612 high-level ED visit, just reading that you would think there would be clinical differences there. So I think option three captures that, that there will be some. But like we were talking about the x-ray, I don't buy that one. So I would vote for three.

DR. WORZALA: I just want to say one thing about emergency services that I'm not sure I said. I did in the paper, and I did another analysis in the paper that I didn't even present here because I felt like it was data overload. But the payment system for emergency services is that there's a payment for the visit. So for the assessment, the triage, that sort of thing. But everything that's done during the emergency visit is also paid. So if you get a cast, you need an x-ray, those services also ring the register, as it were.

The analysis that I did on a claim-level basis as opposed to a service-level basis was really trying to get at this notion of whether or not outlier payments were concentrated on people where you thought there would be variability like emergency services. So I categorized each claim as being an emergency visit first, hierarchical determination, and then after that a major procedure, after that chemotherapy, trying to say, why

would you come to the outpatient department. When you look at it that way you still don't see that there's a lot of outlier payments coming to emergency visits, which I thought was rather surprising. It had an even outlier and total payment percentage.

So conceptually you would think that was true. The way the system is working currently it's not true. But I did want to make clear that we're not talking about all of the services provided in an emergency visit when we take that code 0610.

DR. REISCHAUER: Why isn't it practical to have a clawback provision that whenever an audited cost report is completed you plug it into the computer and it goes back and calculates the over or underpayment in the outlier system, which would remove a tremendous of the incentive here? With interest.

DR. WORZALA: I believe that is being done for the inpatient outlier. On the outpatient side we do have millions and millions of claims, so I think it would be a fairly significant administrative effort to do that. It's certainly not impossible.

DR. REISCHAUER: That's what you have computers. They do these kinds of things for you.

DR. MILLER: Do we have any sense of -- this is probably not a fair question but do we have any sense of how many and how long it takes for completing an audit report?

DR. REISCHAUER: So what? You're removing the incentive.

DR. MILLER: Eliminating it would too.

MR. HACKBARTH: Let me ask this. Is there any sentiment in favor of just eliminating outlier payments, which I think was option one on Chantal's list? Any sentiment in favor of option one which was to eliminate outlier payments altogether for these services?

MS. DePARLE: It would just mean that the 2 percent would be preserved in the spending on outpatient services?

MR. HACKBARTH: Yes, go back into the base. So it would have distributive implications but not aggregate spending implications.

MS. DePARLE: Alice made the most compelling case. Sitting here looking at it I'm embarrassed that we even implemented this, frankly. I don't understand it.

DR. WORZALA: Don't be too embarrassed. The proposed rule didn't have an outlier and it was mandated by Congress.

MR. HACKBARTH: I guess I'd worry some about there being some variability, particularly in the services that involve larger bundles, so to speak. The cost to charge ratio is just so problematic that I wonder whether we do more harm than good using that mechanism. It rewards gaming of the system and the dollars just may not be getting to the right place at all.

MS. ROSENBLATT: In small amounts you're multiplying by three. It's pretty easy to get there it sounds like.

DR. WOLTER: I suppose one option would be to combine two and three and suggest that a more limited universe of outliers be created looking at services and dollar bundles so that there's still some flexibility and yet we're moving in the direction of taking a lot of the gaming out of the system especially for the small dollar numbers.

MS. DePARLE: Nick, I hear you but the agency has to implement all this stuff in the Medicare bill plus a prescription drug benefit. Is it really worth it? Is this achieving -- I guess we need to hear from some hospitals that think it's really doing something to help them meet the needs of their patients. But so far I don't think this would be worth having spent at CMS spend time trying to get this right.

MR. MULLER: First of all, I would say that, as Chantal's presentation indicated, we're finding out some data on '01 now, so I think the outlier provision was put in more when we didn't know what was going to happen. If we go back three years there's incredible uncertainty as to what actually was going to happen, whether the APCs were even remotely on target or not. We had all those corridor payments and hold-harmless and all that kind of stuff, as you know. So I think now three years later we know a little bit more about it and it turned out to be a little closer to where people hoped it would be as opposed to just being way off the mark in terms of meeting costs and so forth.

So I think this probably less thrust for it now than there would have been three years ago when there was all kinds of uncertainty. So in some ways, one way of making an argument against it in some ways is saying, three years later, now that we have some data on 2001, it doesn't seem that we were as far off as we might have thought we were and we made all those kinds of protections. I think in some ways there was a fear that on some of these services one could be off 50, 80, 100, 200, 300 percent, and there is not substantial evidence that that in fact has occurred. So that in many ways could be a persuasive argument for saying, doesn't seem to be as big a problem.

On the other hand, not all these are totally narrowly defined and the purpose, as Glenn just said, of having outliers sometimes -- we have 570 APCs, we have 510 DRGs, so it isn't as if -- to use arithmetic, to use the phrase of the day -- the bundles aren't that much more narrow than some of the DRG bundles and so forth. So you could make an argument by having some possibly, and one thing to do is just you can kick the threshold up even more, is one way of really making a note for the very extreme cases. So I think having a couple suggestions

on that, but I think one fair statement is this is the first time I've really seen data on this in terms of what happened in '01 so I think letting people start understanding what actually happened is going to be helpful.

MR. HACKBARTH: The problem, of course, with just kicking up the thresholds is you're still relying as your basic took on the cost to charge ratio which is so problematic, which is I'm sure where Bob's coming from in saying, if you can do something that would reduce the opportunity, the incentive to manipulate that number, that would give you some confidence then you could have a system maybe with higher thresholds and it be reasonably fair. But right now it's just --

MR. MULLER: You have a cost to charge ratio for the whole hospital. You don't have it -- you can't do one on cardiac and another one on oncology. You can't just manipulate it that way.

MR. HACKBARTH: The graph that Chantal showed, over the last 15 or 20 years, the decline in the aggregated cost to charge ratio from 75 down to 42, that just screams at you this is a giant game. If we continue on this rate for the next 15 years we're approaching zero on our cost to charge ratio.

DR. REISCHAUER: Even if you did what I suggested, you could manipulate the cost to charge ratio for services that were heavily used by Medicare patients versus other ones and the hospital's ratio on average would be a biased thing, so there's still a game to be played.

MR. HACKBARTH: So I think I hear consensus that the status quo is not desirable and we need to make a change here. The options on the table are eliminate completely or maybe do a combination of two and three, which is focus on our services with some variability and have the front-end threshold.

DR. WORZALA: We can also pick up Bob's suggestion of asking the Secretary to settle the outlier payments on the cost report, which is what they're doing on the inpatient side. But before we do that I would like to better understand what that would entail on the part of the agency and the FIs.

DR. REISCHAUER: We could mix all three and have this phase out but in the first stage being we raise the threshold, give the Secretary a little bit of flexibility to bump out some things that shouldn't have a lot of variability, reduce the aggregate to 1 percent or something like that, and then three years have it disappear.

MR. HACKBARTH: We don't need to resolve this today. Any other thoughts that people want to give Chantal to look at in the next month?

Okay, thank you very much.

DR. WORZALA: Actually I forgot until Sarah mentioned that there's some data on transitional corridor payments. Do you

have the stomach for that after all this?

MR. HACKBARTH: Sure.

DR. WORZALA: I think I will skip over the set-up for the transitional corridor payments unless anyone feels like they need a review of what they are or how they work, and get to the data since again this is something that has not been seen. One thing I will point out is that the calculation of the transitional corridors is also dependent on the cost to charge ratios because we first must estimate the cost in calculating the payment, and there's an interim payment with settlement on a cost report.

These are data from the 2001 and 2002 cost reports. What I'm looking at here are the share of PPS payments that came through transitional corridor payments. So it's transitional corridor payments divided by PPS payments plus transitional corridor payments. The 2001 number I believe is about 95 percent of hospitals. 2002 is 60 percent with no imputation for missing hospitals.

We can see that altogether in 2001 these payments represented about 2.3 percent of all payments, rising to 2.6 percent in 2002. That compares to a projection of 4.4 percent on the part of CMS when they put the rule out. So we might conclude that hospitals are actually doing better transitioning into the PPS than was expected. Alternatively, you could say that the data available to CMS when they made that estimate wasn't the best and they did the best they could with the data and there's a difference there.

It's a bit surprising to see an increase in the transitional corridor payments rather than a decrease since the policy is supposed to be phasing down traditional corridor payments. That trend may not hold with a full sample of hospitals. But it could be a real phenomenon if the difference between PPS payments and payments estimated from previous payment policy grew by a fairly substantial amount between those two years. Again that would involve cost to charge ratios and payment to cost ratios in making those calculations.

If you look at these shares you see that small rural hospitals received a greater share of total PPS payments from transitional corridors. The rural one to 100 beds, it was 4.7 percent in '01 and 6.4 percent in '02. Also we see that the major teaching hospitals report a higher share of payments from transitional corridors as well, about 5 percent in each of the two years.

As we talked about this morning, the current legislation does extend those hold-harmless payments for the small rural hospitals for two years and also extends them to all sole community hospitals regardless of size. About 85 percent of the

sole community hospitals have 100 or fewer beds. It also requires a study by the Secretary of the cost of rural hospitals compared to urban under the outpatient PPS and a look at the need for a payment adjustment for rural hospitals.

We had put this on our agenda for this year because our 2001 report suggested that there may be some factors that would make the outpatient PPS more difficult for small rural hospitals to adjust to. We've been a little bit frustrated over the last two years that there hasn't been any data, which we now have of course. But I don't know that, given the current legislation, the Commission wants to do anything else with. So I bring that for your direction.

MR. HACKBARTH: Comments?

DR. WOLTER: A question. I didn't quite catch that. The legislation extends this to sole community hospitals; is that what you said, or what bed size?

DR. WORZALA: Any bed size. However, about 85 percent are 100 or fewer beds. So there are about 15 percent of small community hospitals who will benefit from this provision that didn't previously, so it comes with a small price tag.

MR. HACKBARTH: I'm sensing that we're at the end of our useful life for today. We're going to take this other advisement I think it and retire to our chambers.

Thanks, Chantal.

DR. WORZALA: Please let me know if you want additional analysis by January.