

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:

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ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
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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.

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1 P R O C E E D I N G S

2 MR. HACKBARTH: Welcome to our guests. If you
3 could take your seats, please.

4 Today and tomorrow we will be completing at
5 least the public segment of our work on the March 2004
6 report, and that includes our votes on update
7 recommendations for the various sectors.

8 This morning we begin with dialysis. Nancy?

9 MS. RAY: Good morning.

10 Recall last month we discussed two aspects of
11 outpatient dialysis payment policies. First, we
12 discussed assessing payment adequacy and updating the
13 composite rate for 2005. We do this annually so that
14 Medicare's payments can cover efficient providers' costs
15 and in doing so maintain beneficiaries' access to care.

16 The second issue we discussed last month
17 concerned linking payments to quality, and in doing so
18 improving the quality of outpatient dialysis care.

19 Currently Medicare has no mechanism to
20 directly reward providers and here we're talking about
21 dialysis facilities and the physicians who treat
22 dialysis patients who improve quality. Recall that in

1 our June 2003 report the Commission endorsed using
2 quality incentives.

3 So let's move on to our assessment of payment
4 adequacy. Our framework examines six factors to assess
5 payment adequacy and the first is beneficiaries' access.
6 Here we've concluded that beneficiaries don't appear to
7 be facing systematic barriers in accessing care. We did
8 an analysis of the pattern of facility closures, and
9 this suggests that beneficiaries should not be having
10 problems accessing care in rural areas, HPSAs. In
11 addition, the percentage of the population that is
12 minority and that the percentage of the households
13 receiving public assistance income does not appear to be
14 correlated with facility closures. Rather, facility
15 closures seem to be associated with facilities that are
16 small, hospital-based, and non-profit.

17 A second factor we consider in our payment
18 adequacy framework is the volume of services. And here
19 we've looked at the volume of services in terms of
20 Medicare payments because we don't have a common unit.
21 And let me just spend a little bit of time talking about
22 each of these bars.

1 The first bar shows the average annual growth
2 in payments for composite rate services between 1996 and
3 2001. These have been growing by about 6 percent. The
4 growth is primarily being driven by the growth in the
5 beneficiary population, which is also roughly at about 6
6 percent.

7 The next bar shows a 12 percent average annual
8 growth in payments for erythropoietin. This bar, the
9 increase is being driven both by the increase in the
10 patient population as well as by the increasing dose of
11 erythropoietin between 1996 and 2001. Recall that
12 erythropoietin, the payment rate is set by Congress and
13 that payment rate was not changed between 1996 and 2001.

14 The third bar is the rate of growth for other
15 injectable drugs. This includes vitamin D analogs,
16 injectable iron, injectable antibiotics. Between 1996
17 and 2001 the average annual growth in payments for these
18 drugs was about 25 percent. The growth in these
19 services is being driven by a combination of the growth
20 in the patient population, the increasing acquisition
21 cost because there has been some substitution from older
22 drugs to more new costly drugs.

1 Your mailing materials also note that there is
2 some variation in the use of these drugs by provider
3 type.

4 So here we can conclude that the volume of
5 services is growing, is keeping up with the number of
6 patients.

7 A third factor we look at in our framework is
8 quality of care. Here we've concluded that quality is
9 improving for some measures. CMS's data shows
10 substantial improvements in dialysis adequacy and anemia
11 between 1993 and 2001. However, CMS's data also show
12 that other measures are flat, specifically nutritional
13 measures and vascular access care. I think this
14 demonstrates the need for continued efforts to improve
15 quality and to address these continued concerns about
16 dialysis quality. Later on in the presentation we will
17 discuss the use of quality incentives as a means to
18 improve quality.

19 This slide shows the proportion of for-profit
20 facilities is growing. We show this as an indirect
21 measure this time of access to capital, which appears to
22 be sufficient. Last month you had asked about the

1 growth in the for-profit chains and where this growth
2 was coming from. So we compiled information from their
3 SEC filings and annual reports and that showed that in
4 2002 the four major national chains, they opened 104
5 facilities and acquired 35 facilities in 2002. So
6 between the openings in 2001 and -- I'm sorry, total
7 number in 2001 and total number in 2002, there was about
8 roughly a 5 percent growth in the number of facilities
9 operated by the four major chains.

10 Just to give you a frame of reference, in 2002
11 there was a total of about 4000 dialysis facilities and
12 about two-thirds were operated by these four national
13 chains.

14 Let's move on now to the Medicare margin.
15 Here we have calculated it for 2001. We used 2001 cost
16 report data because of the low proportion of facilities
17 that are in the file available from CMS for 2002.

18 So here we see that the Medicare margin is 5.2
19 percent for all facilities, 5.4 percent for urban
20 facilities and 4.3 percent for rural. These 2001 data
21 are adjusted by an audit factor. 1996 is the most
22 recent year that cost reports were audited. Our

1 analysis indicates that audited costs are 96 percent of
2 reported costs. Recall that ProPAC included an audit
3 factor in their update analyses and an older audit found
4 that audited costs were 88 percent of reported costs.

5 I do want to mention here that data presented
6 by the major chains, they have used their 2002 data and
7 they have calculated a 2002 margin of basically zero,
8 roughly zero. We have a couple of concerns with this.
9 First, it does not include the audit factor. And
10 second, we have issues with how they have cleaned the
11 data.

12 So now let's move on to our estimated Medicare
13 margin for 2004. We start our estimation process by
14 beginning with our 2001 payments and current law does
15 not update the composite rate for 2002, 2003 or 2004.
16 So projecting out our 2001 data to 2004, it yields a
17 margin of 2.7 percent. This includes a conservative
18 assumption about the increasing proportion of payments
19 for injectable drugs relative to composite rate
20 services. If you remove that conservative assumption,
21 the margin would be lowered by .6 of a percent. So it
22 would be lowered to 2.1 percent.

1 So to summarize, our analysis of market
2 factors suggest that beneficiaries are not -- go ahead

3 MR. HACKBARTH: I was thinking about what you
4 just said and I just want to make sure I understand the
5 nature of the conservative assumption.

6 MS. RAY: Here's what we did. If you recall
7 in your mailing materials, we showed that the proportion
8 of payments for injectable drugs relative to composite
9 rate services has increased from 1996 it was 30 percent.
10 In 2001 it was 40 percent. But I only used the most
11 recent three-year trend from 1999 to 2001. And there
12 it's actually -- it's a 37 percent to 41 percent
13 increase. So the 2.7 percent number would have been
14 higher if I used the '96 to '01 trend for the longer
15 time period because the share has increased more for
16 that time frame than the most recent couple of years.

17 DR. ROWE: [off microphone.] So what do you
18 think the Medicare margin actually is?

19 MS. RAY: The Medicare margin is 2.7 percent
20 if we -- when we project out from 2001 to 2004, if we
21 increase the share of injectable payments relative to
22 composite rate payments from 41 percent to about 43

1 percent.

2 MR. HACKBARTH: And if we assume that there's
3 no growth.

4 MS. RAY: Then it would be 2.1 percent. I'm
5 sorry if I wasn't clear the first time.

6 DR. ROWE: So it's 2.1 to 2.7 percent.

7 MR. HACKBARTH: 2.1 if the relationship
8 between injectables and dialysis stayed the same as it
9 was in 2001.

10 MS. RAY: Yes.

11 MR. HACKBARTH: 2.7 if injectables d continued
12 to grow relative to the composite payment.

13 MS. RAY: Yes.

14 So to summarize our market factors, again no
15 systematic problems in accessing care for beneficiaries.
16 I showed you at the last meeting that providers seem to
17 have sufficient capacity to treat patients. The number
18 of in-center hemodialysis stations is keeping up with
19 patients. There is a growing volume of services, as
20 indicated by the payment data. We see improving quality
21 on some measures. And there appears to be sufficient
22 access to capital.

1 So moving to the second part of our update
2 framework, how should Medicare change payments in
3 calendar year 2005? There are two important factors to
4 consider here. The first, our framework reflects our
5 policy goal that in the aggregate providers should be
6 able to improve their efficiency while maintaining
7 service quality.

8 The second is the change in input prices
9 between 2004 and 2005. Past years we've solely relied
10 on the Commission's market basket to estimate the costs
11 in the next payment year. And so the Commission's
12 market basket estimates costs will rise by 2.3 percent
13 between 2004 and 2005. CMS just released their dialysis
14 market basket, they released it this year. This market
15 basket estimates costs will rise by 3 percent between
16 2004 and 2005.

17 Our likely direction is to move to the CMS
18 market basket in the future. However, we have a few
19 technical issues that we raised in our October report on
20 modernizing the dialysis payment system and we would
21 like to work with the Agency on these issues. The two
22 important issues are the weighting of the cost

1 categories and the change in the distribution of
2 services when audited data are used.

3 So using these two market baskets and
4 including our policy goal for productivity, we estimate
5 that efficient providers' costs will rise by 1.4 to 2.1
6 percent between 2004 and 2005. That tenth of a percent
7 difference is because of the new dialysis market basket
8 that CMS just released.

9 Let's just briefly discuss the two important
10 payment changes by DIMA in 2005. DIMA increases the
11 composite rate by 1.6 percent. DIMA also makes another
12 important change to the outpatient dialysis payment
13 system. It case-mix adjusts the payment for composite
14 rate services and the difference between payments for
15 and the cost of injectable drugs. That is the spread on
16 the injectable drugs. It also pays the acquisition
17 costs for injectable drugs.

18 Just to let you know, to keep this in mind,
19 that CBO scored this latter provision, the case-mix
20 adjustment and the paying based on the acquisition
21 costs, as budget neutral.

22 So this led us to our draft recommendation

1 that Congress should maintain current law and update the
2 composite rate by 1.6 percent for calendar year 2005.
3 This would have no spending implications relative to
4 current law.

5 DR. ROWE: Thank you, Nancy.

6 I need some help and here's my concern.
7 Somewhere along this logic train I'm making a serious
8 mistake but Medicare is the major source of revenue for
9 many of these facilities. And thus, the Medicare margin
10 is probably a reasonable proxy for the overall margin
11 unless commercial payers such as myself are paying
12 something that's much, much higher and represents a much
13 larger portion of the population, and I think we do.
14 But you can tell us what the overall margins are.

15 You're talking about overall margins depending
16 on this one issue we're talking about. Pre-tax, I'm
17 assuming, this is pre-tax of 2.1 to 2.7 percent, and CMS
18 says the costs are going to increase 3 percent. We
19 differ a little bit with their analysis and we think the
20 costs may increase somewhere between 1.4 and 2.1 percent
21 and we're going to increase by 1.6 percent. We're going
22 to drive these people out of -- I don't understand how

1 they can have access to capital at that rate. I don't
2 understand how their stock prices are doing so well. I
3 don't understand why more people are entering the
4 market. There's something wrong here. What am I
5 missing? Where are they making the money?

6 DR. NEWHOUSE: [off microphone.] Epo.

7 DR. ROWE: But epo is paid by Medicare.

8 MR. HACKBARTH: The margin is calculated
9 including the drugs.

10 DR. ROWE: No. The Medicare margin was 2.1 to
11 2.7 inclusive, everything that Medicare pays for. So
12 that's not the answer. What is the answer?

13 DR. MILLER: Let me ask one thing to clarify.
14 The margins that we reported, the 2.7, includes the
15 drugs and the composite rate?

16 MS. RAY: Yes.

17 DR. MILLER: So that's the first
18 clarification. And then the second point is this
19 update, the 1.6, applies to the composite rate?

20 MS. RAY: Yes.

21 DR. ROWE: So is there any increase in the
22 drugs?

1 MS. RAY: Drugs will continue to be paid as
2 they occur --

3 DR. ROWE: But this DIMA thing is budget
4 neutral.

5 MS. RAY: That's right. For 2005, that's
6 right.

7 DR. ROWE: So why wouldn't a prudent investor
8 buy a share of these -- I mean, I must be missing some
9 huge thing here.

10 MR. SMITH: [off microphone.] Budget neutral,
11 Jack, doesn't mean less money. It means less money
12 relative to current law. It will be more money --

13 DR. ROWE: I understand, but is there enough
14 there to make this a -- are these pre-tax margins, first
15 of all?

16 MS. RAY: The margins represent Medicare
17 payments to allowable costs.

18 DR. ROWE: So if we take a number like 2.5, so
19 that's 1.5 after tax. That's inconsistent with the
20 access to capital, the stock performance, the increase
21 in the -- isn't it?

22 MR. HACKBARTH: I think, in part, Jack, this

1 is why we look at factors other than just the margin.
2 All of the other indicators, including the rapid growth
3 of the for-profit piece of the industry, suggest to me
4 that the payments are adequate.

5 DR. ROWE: I understand. I agree. Are the
6 returns on capital -- do you know what the returns on
7 capital are?

8 DR. REISCHAUER: You don't look at the margin
9 on revenues to determine the profitability of a company.
10 I mean, supermarkets operate at less than 1 percent.
11 It's the invested capital.

12 DR. ROWE: I understand. I just asked what
13 the return on capital was.

14 MS. RAY: I'd have to get back to you on that.

15 DR. ROWE: I'm not trying to make a case for
16 or against. I'm just trying to connect all these dots
17 and I'm asking what I'm missing. And maybe the returns
18 on capital are 35 percent, for all I know. But I would
19 think this is a pretty capital intensive business and,
20 in fact, they're not that high. But I don't know.

21 It's a puzzlement, but thank you for telling
22 me how you measure the profitability of a company. I

1 appreciate it.

2 DR. REISCHAUER: You asked what you were
3 missing and you beat up Nancy left and right. And then,
4 at the end, you try and slip in something so we don't --

5 DR. ROWE: That's why I thanked you but I
6 slipped it in before you mentioned it.

7 MR. HACKBARTH: Usually, it takes us a while
8 to get to this point, and here we are the first
9 presentation. Sheila?

10 MS. BURKE: Nancy, good job. I have a couple
11 of questions on the chapter and how we describe what's
12 going on as compared to Jack's issue around the
13 recommendations.

14 Twofold. One, there is a discussion in the
15 chapter about two-thirds of free-standing facilities
16 that were opened and your comment about the continued
17 opening of free-standing, and the comment made that the
18 openings suggest that there is adequate profitability
19 and access to capital.

20 What is not discussed in the chapter at all
21 is, in fact, the implications of the absolute decline in
22 non-profits, the continued decline and the continued

1 increase in for-profits and what, in fact, is occurring
2 with respect to the non-profits. There is an
3 observation that's specific to the adequacy related to
4 for-profits. There is nothing about why, in fact, we
5 continue to see a decline in non-profits in our
6 discussion. And so that's just an area that we may want
7 to give some attention to.

8 The second issue is really my trying to
9 understand, although this is a relatively small
10 percentage of the population, and that is what is
11 occurring with those patients who have chosen to do in-
12 home as compared to in-center dialysis?

13 In the conversation you talk a bit about the
14 inequity of the treatment of drug costs for the home-
15 based patient who only has epo taken care of, but none
16 of the other drug costs. And of course, the new
17 legislation will potentially exacerbated -- well, it
18 certainly won't do anything to address has issue with
19 respect to the in-home patient.

20 I wondered whether there was attention that
21 needed to be given to that patient, what was happened
22 with respect to the equity issues with the in-home

1 patient, whether the policies in fact continue to
2 encourage people to go in-center, and if there is a
3 reason to do that for purposes of quality. Because the
4 other issue that is not specifically pointed out is you
5 note that there has been some progress in the context of
6 some measures but less so in others. What I don't know
7 is whether there is a difference between the measures
8 quality and the impact on the in-center patient and the
9 at-home patient, whether we see dramatic differences,
10 whether it is in nutrition issues, presence of anemia,
11 issues in terms of the site treatment.

12 It would be helpful to understand do we want a
13 policy that, in fact, encourages people to go in-center
14 as compared to stay at home? And has there been a
15 radical difference, or is there a real difference in the
16 quality indicators between those two sets of patients?
17 And if there is, then it would seem to me that should
18 relate to some kind of a policy over the long term in
19 terms of reimbursement and what it is we want to
20 encourage or discourage.

21 Again, it's a relative small percentage of the
22 population but it is still a continuing population that

1 has chosen peritoneal and chosen to stay home.

2 MS. RAY: Right. Just two points to add on,
3 and we will definitely augment the chapter with the
4 quality information and address those points. Just two
5 points right now, however.

6 Remember that the composite rate as its
7 constructed right now actually gives an incentive for
8 peritoneal dialysis. And despite that incentive, and I
9 included this in your mailing materials, the proportion
10 of peritoneal patients has declined roughly by about 10
11 percent in the last decade.

12 MR. FEEZOR: [off microphone.] Incentive to
13 whom?

14 MS. RAY: If you just looked at the composite
15 rate payment to the provider because peritoneal costs
16 are, on average, lower than the in-center because you
17 don't have the capital costs.

18 DR. REISCHAUER: Nancy, on page 16 you
19 referred to the fact that some of these chains have
20 their own laboratories and it wasn't clear whether you
21 were saying they make excess profits in the laboratory
22 business and those aren't reflected in these margins,

1 that they overuse laboratory service because of this. I
2 think if we're going to put something like this in, we
3 have to say why we're doing it and whether it's really
4 relevant whether that's within the same corporate entity
5 versus there's some independent laboratory somewhere
6 that's making a bundle on this. It sort of made me a
7 little uncomfortable the way we had it in the text.

8 MS. RAY: I was not in any way meaning to
9 suggest that there's any overuse of laboratory services.
10 Rather, there are certain laboratory tests that are paid
11 for outside of the composite rate if they go above a
12 certain amount per month and so forth. So those are
13 sent out to the laboratory and Medicare pays the
14 laboratory. It just so happens that the national chains
15 own their own laboratories.

16 So the payments and costs associated with
17 those services that are associated with the dialysis
18 treatment are not included in our payment margin.

19 DR. REISCHAUER: I understand that, but we
20 don't want to have a payment that's adequate only if you
21 run a laboratory on the side. What you're basically
22 saying is so these guys might not go out of visit

1 because they're selling cars or doing something else on
2 the side. But that's really not relevant to what the
3 payment level should be for dialysis treatment.

4 MS. RAY: I was not suggesting that, but in
5 keeping with our recommendation of broadening the bundle
6 and including all services to the extent possible
7 associated with the dialysis treatment, just like our
8 margins have included the use of injectable drugs in a
9 perfect world, we have included separately billable
10 drugs, we would want to include these separately
11 billable lab tests because they are associated with the
12 dialysis treatment. And we can't because it would be --
13 well, we not yet because it's a very tough claims level
14 analysis to do that.

15 But the fact remains that I think ultimately
16 we would want to include these in the broader bundle.
17 And that's why I mentioned them when we're thinking
18 about payment adequacy.

19 DR. REISCHAUER: [off microphone.] I agree
20 with that but there's sort of an innuendo here.

21 MS. RAY: I hear you. We'll address that.

22 MR. FEEZOR: Nancy, three questions. Sheila

1 touched on one about the quality of home versus
2 institutional. But in your access, was there any
3 significant difference between CON and non-CON states,
4 that you could determine? Or was that discernable?

5 MS. RAY: I did not do it that way. For the
6 next cycle we could take a look at that.

7 MR. FEEZOR: Moving to the patient
8 satisfaction survey that's coming online, will we be
9 able to break down -- will that, do you think, reflect
10 such issues as drive time, so that we'll have yet a
11 finer, more granular cut in terms of access?

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

13 MR. FEEZOR: We have a patient satisfaction
14 survey that's coming online, right? I was just trying
15 to find out if that would hit such things as differences
16 between say small facilities versus large facilities,
17 drive times, and things like that. Do you know?

18 MS. RAY: I'm going to have to check with AHRQ
19 and CMS to see exactly what measures they're including.

20 MR. FEEZOR: Do you know whether any of the
21 licensure requirements which of course is largely state
22 as well, whether they have any required backup capacity

1 so that if in case of disasters or major dislocations?
2 I'd love to hear that. That's something we've seen some
3 experience in that probably needs to be looked at, not
4 so much from this body but the industry at large.

5 MS. DePARLE: At our December meeting, we
6 talked some about using the CMS market basket versus the
7 one that we had been using for some time. And it sounds
8 like you're inclined to move towards the CMS one. But
9 in the discussion of the chapter you raised two issues
10 about it, that CMS does not indicate how frequently the
11 base weights will be updated, and that CMS does not
12 specifically address whether it used audited cost report
13 data. Have we asked them? Those seem like pretty
14 simple yes or no questions to figure out.

15 MS. RAY: We're in the process of talking.

16 MS. DePARLE: Does that mean that this might
17 change between what we vote on today and when -- it
18 seems like they could answer this pretty quickly. And
19 if they did, then might we not just say okay, we're
20 going to use CMS's market basket?

21 DR. MILLER: Nancy Ann, CMS is thinking about
22 these issues. We have not gotten an answer yet.

1 MS. DePARLE: But we have asked them?

2 DR. MILLER: We have asked them and I would
3 not anticipate getting answers between now and when we
4 have to go to print.

5 MS. DePARLE: These questions seem like simple
6 ones and it always used to annoy me when people wouldn't
7 just ask. Did you use audited cost report data or did
8 you not?

9 DR. MILLER: I can assure you we're not just
10 sitting in our offices. We have definitely asked this
11 question and I think CMS is thinking about what went on
12 and what they would do to address these issues.

13 MS. DePARLE: Just one more thing. I haven't
14 gotten to make this point yet this morning. Is this
15 2001 data we're basing this off of, am I right?

16 MS. RAY: The cost report? Yes.

17 MS. DePARLE: So we're making a recommendation
18 for 2005 and, I know you agree with this but...

19 MS. RAY: The 2002 cost report file had about
20 40 percent of all the facilities. It was just way
21 underreported compared to previous years.

22 MS. DePARLE: Let's break that down. That's

1 because they don't turn them in on time?

2 MS. RAY: I don't exactly know the reasons for
3 that. It could be the facilities. It could be the FIs.
4 It could be CMS. There are a number of steps here that
5 are involved.

6 MS. DePARLE: It seems to me that everyone,
7 all of those people, have an interest in having accurate
8 data. I know we do. So I don't know if there's some
9 way to reflect that in our recommendations but there
10 aren't many businesses where I think you'd be making
11 recommendations about what to pay for a year from now
12 based on data from four years ago. Thanks.

13 MS. BURKE: If I could just add, Nancy and
14 Nancy Ann, the same thing struck me when I read in the
15 text that only 41 percent of the '02 cost reports were
16 available. And I think, in fact -- that's simply stated
17 as a fact in the text. I would, in fact, say something
18 further about that, that our preference would be
19 certainly to have been, but unfortunately for a variety
20 of reasons -- something to highlight the fact that we're
21 basing it on '01 because we didn't have '02, or we only
22 had 40 percent of '02 is just outrageous. I think we

1 ought to make note of that fact. It's not that that
2 would be our preference by any stretch.

3 DR. ROWE: On page 13, you do include the
4 returns on -- the term you use is return on equity.
5 There's return on capital, return on economic capital,
6 different kinds of ways to look at this. But return on
7 equity, the range is 11 to 65 percent, which is a
8 modestly broad range so it's hard to know how to
9 interpret that.

10 But you do also indicate that three-quarters
11 of the patients are on Medicare and that they account
12 for about 57 percent of the revenues. So pushing some
13 numbers around here a little bit, it does look as if
14 they're making from the commercial payers, whoever they
15 may be, significantly more if the costs of all patients
16 are the same. But since that's only one-quarter of the
17 patients when you add it all up, I still only get to
18 returns that are less than 5 percent, in the 3 percent
19 range pre-tax. So it still is modest.

20 Although as I say, it seems inconsistent with
21 the stock prices going up and the access increasing and
22 everything else. So it just doesn't seem to meet what

1 most investors would see as attractive. So I think it's
2 worth pushing this around, talking with some analysts
3 who are in this space and getting a sense of it so we
4 can connect the dots.

5 MR. SMITH: But, Jack, as you push the numbers
6 around, I the problem is you're still assuming that the
7 return on capital is the weighted average of the margins
8 from different payers. It's not true. The return on
9 capital is the pre-tax profit of the operation over the
10 equity invested by investors.

11 DR. ROWE: I'm accepting the return on capital
12 on page 13.

13 MR. SMITH: I understand but the return on
14 capital and the weighted average of the margins by
15 payers will not be equal. These folks are in the real
16 estate business, among other things.

17 DR. ROWE: I understand.

18 MR. SMITH: So trying to figure out why they
19 aren't the same thing, I don't think, is a very useful
20 exercise.

21 DR. ROWE: I'm not trying to equate them. I
22 see them as related not necessarily orthogonal but two

1 separate ways to look at the valuation and I'm just
2 trying to understand with the numbers we're given why --
3 it just looks to me like maybe they're making a lot more
4 on Medicare than we're calculating is the point here.
5 That's my point because if they weren't why are they
6 doing so well.

7 MR. SMITH: That's a possible inference, for
8 sure.

9 DR. ROWE: We just need to go through the
10 whole thing again and make sure we got this right.

11 MR. HACKBARTH: We need to move on to the
12 second recommendation. Nancy, do you want to do that
13 piece of the presentation?

14 MS. RAY: Recall that the Commission expressed
15 an urgent need to improve quality in our June 2000
16 report and endorsed the use of linking payments to
17 quality. Medicare does not have a mechanism to directly
18 reward facilities and physicians treating dialysis
19 patients for improving care and making investments in
20 improving care. Although adequacy in anemia status has
21 improved, other measures have not. And, as pointed out
22 in your mailing materials, mortality and rates of

1 hospitalization remain high with very little change over
2 the past decade.

3 We looked at the feasibility of implementing
4 quality incentives for outpatient dialysis services.
5 And here we conclude that it does appear to be feasible.
6 Again, I just want to make it very clear by the dialysis
7 sector we mean both dialysis facilities and physicians
8 treating dialysis patients. The actions of both
9 facilities and physicians affect patients' quality of
10 care.

11 So we looked at four aspects to assess the
12 feasibility of implementing incentives. We do have
13 measures are available that are evidence-based,
14 developed by third parties, and agreed upon by the
15 majority of providers. CMS can collect provider-
16 specific information without excessive burden on
17 providers. Data on adequacy and anemia are collected on
18 claims. And there is an ongoing effort to collect
19 clinical data by linking facilities with the ESRD
20 networks and CMS.

21 Data are available to case-mix measures so
22 that providers are not discouraged from taking riskier

1 or more complex patients. As set forth in your mailing
2 brief, providers are required to report clinical
3 information about each patient when they are incident.
4 There are some 17 comorbidities, patient weight, ability
5 to ambulate and transfer. Of course, this information
6 can always be augmented by Part A and Part B payment
7 claims.

8 Finally, history has shown that providers can
9 improve upon some aspects of quality, at least on
10 adequacy and anemia status.

11 Your mailing materials include some key
12 implication issues that the Secretary will need to think
13 about when implementing incentives.

14 We were guided by two principles when thinking
15 about these implementation issues. First, that the
16 incentives, there their improvements on quality should
17 reach as many patients as possible. And two, that their
18 adverse consequences, such as cherry-picking, should be
19 minimized.

20 So some of the key implementation issues
21 include how should quality be measured. Here we've
22 discussed basing it on a combination of both quality

1 improvement and meeting national averages or targets.
2 By using both methods, providers at both ends of the
3 quality spectrum will be able to be rewarded. In this
4 way we will be reaching a large share of providers.
5 Consequently, the quality improvement effects of
6 incentives will touch upon as many patients as possible.

7 Second, how would you pay? In here, we
8 discuss basing this on a small share, say 1 percent of
9 total payments. This would discouraged providers from
10 de-emphasizing other quality improvement efforts and it
11 would minimize the adverse effect on providers who do
12 not meet the quality criteria.

13 We spent a fair amount of time discussing
14 which quality measures used. Here we think that aspects
15 of dialysis adequacy, anemia, nutrition, vascular access
16 and bone disease can all be linked to payment.

17 Finally, your mailing materials include other
18 implementations the Secretary will need to consider,
19 including collaborating with patients and provider
20 groups, keeping the measures current over time,
21 developing uniform ways to measure the indicators, and
22 to verify the data collected.

1 Finally, it's worth noting that this will
2 increase the administrative responsibilities for both
3 CMS and its contractors.

4 So this led us to our second recommendation,
5 that Congress should establish a quality incentive
6 payment policy for outpatient dialysis services. This
7 has no spending implications relative to current law.

8 MS. ROSENBLATT: I'm going to make this point
9 when we talk about M+C as well, and I think I made this
10 point at our last meeting. I think doing quality
11 incentives is great. My concern is in the context of
12 the Medicare system and the way it's funded, what does
13 it mean to set aside a pool of money for this?

14 Because if we were doing it in the private
15 sector, as many do, in an HMO, a lot of capitated
16 payments end up with a withhold. And that withhold
17 money is actually set aside, a liability is established
18 on the balance sheet. You can point to it. There's
19 sort of real money being put aside.

20 My concern in this context is just what does
21 this mean in the program? Or would all the providers
22 see this as just a way of cutting back 1 percent and the

1 pool of money does not exist. That's my concern.

2 MR. HACKBARTH: Let me make sure I understand.
3 So your concern is that the money "will be withheld" but
4 not necessarily paid out and unless you can see it --

5 MS. ROSENBLATT: It will be withheld but it's
6 not set aside anywhere so it will be spent elsewhere.
7 There's no liability set up for it.

8 DR. MILLER: Again, what we're articulating
9 here are a set of principles, so there's probably
10 different mechanisms that could be thought through, but
11 the cleanest way to do this would be if you decided it
12 was 1 percent, you would pay 99 cents on a claim, have
13 the indication of how much you've paid out. And at the
14 end of the year, based on whatever your measures, cut a
15 second set of checks. I think that's a way it could be
16 accomplished.

17 MR. HACKBARTH: Are you concerned, Alice, that
18 the thresholds for improvement will be set so high that
19 nobody will attain them and so there won't be any payout
20 of quality incentives?

21 MS. ROSENBLATT: That's part of it. What
22 then, if no providers qualify for it and you've ended up

1 decreasing payments by 1 percent?

2 DR. MILLER: One of the things that we're
3 trying to be clear about in setting up -- well, the
4 slide on the principles. There's a couple of things
5 here.

6 We said and articulated all through the last
7 meeting and this meeting, we're going to try to be very
8 clear on this, and this will be true on M+C, too. So
9 just to get out ahead of it.

10 It should be both attainment and improvement.
11 So that a person at a lower end of the distribution, if
12 they move a certain -- and there's lots of ways to do
13 this, percentages, points, whatever is -- they get
14 something.

15 The second way that you assure that the money
16 travels out is you try and determine, either looking at
17 the measures or the percentages -- and the way Nancy was
18 speaking to this is that the most patients are reached
19 by this.

20 Certainly initially you would want this to
21 travel back to -- I don't know what the exact percentage
22 is, but a relatively large percentage of agencies. And

1 you can do that by setting the standards in a way that
2 you're moving up the tail of the distribution.

3 Another point is that Nancy has said very
4 clearly that what we want to do with this is bring in
5 new measures over time. So where everybody is, one
6 concern you might have is everybody's already at this
7 particular measure. But she's been talking about -- and
8 this is where I'm going to lose it here really quickly -
9 - but nutrition and vascular access. Those are new
10 measures and this is the way you keep quality
11 improvement moving is moving up on existing measures and
12 bringing new measures in. And arguably facilities
13 should be able to play on all of that, those dimensions.
14 I think that's the thought.

15 MR. HACKBARTH: There are many specific
16 decisions that need to be made to operationalize this
17 concept of an incentive payment. And we're not CMS.
18 We're not an operating agency. We're not really in a
19 position to dot all of the I's and cross all the T's. I
20 think we would be going beyond our expertise if we try
21 to define it down to every last detail.

22 Conceptually, it is not our intent to withhold

1 money and then not pay it out. Our goal, the objective
2 here is to provide a reward for improving quality. I
3 think it's entirely appropriate for us in the text to
4 emphasize that we want the money paid out to reward
5 improvement. It's not about trying to find another way
6 to take money out of the system.

7 But I don't want to go so far as to define
8 formulas on exactly how it's going to be paid out. I
9 think that would be inappropriate for us to do.

10 MS. ROSENBLATT: Can I just push it a little
11 bit more and ask the question is it feasible for these
12 payments to be made? These types of payments are made
13 by Medicare intermediaries. I don't see Medicare
14 intermediaries being able to do this. I think CMS
15 itself would need to do this, I don't know, maybe issue
16 memos to -- it just seems to me the implementation of
17 this is pretty difficult.

18 I know we can't think through all the details,
19 but I'm just trying to get us to think through at sort
20 of the first cut, are we recommending something that can
21 really happen?

22 MS. RAY: I would just like to put on the

1 table that CMS is already proposing to link payment to
2 quality in the new ESRD disease management demo. So I
3 think the agency has already thought through some of
4 these issues. Again, in the new demo, they will again
5 be paying both on the basis of improvement and
6 attainment.

7 DR. NEWHOUSE: I thought the analogy to what
8 Alice was raising first was was this object neutral ex
9 ante or ex post? So the analogy would be to the
10 hospital outlier system where the threshold is set ex
11 ante, 5 percent is knocked off the base rate, and then
12 however much money is paid out is paid out. And it may
13 or may not be 5 percent at the end of the day versus
14 some system that, in fact, guaranteed that 100 percent
15 would be paid out at the end of the day.

16 I don't have a strong view about whether we
17 should comment on whether this is budget neutral ex ante
18 or ex post, but I think there is still an issue there.

19 DR. ROWE: Nancy is probably expecting this
20 comment, but I think there are two things about this
21 that are really interesting and important. One is that
22 it begins to migrate from a dialysis program to an end-

1 stage renal disease program, which is what it's supposed
2 to be, because we're picking up nutrition and --
3 although that albumin level is a measure of adequacy of
4 management of dialysis patients, it's managed by
5 physicians in many ways. And picking up bone disease
6 and prescriptions for bisphosphonates and vitamin D and
7 calcium monitoring, et cetera, is done by physicians, et
8 cetera, not a dialysis facility, per se.

9 Although, if you put money in for quality it
10 will give the dialysis facilities incentives to hire
11 nutritionists to spend more time with the patients while
12 they're on the machines making sure their diet is
13 appropriate, et cetera, because the patients are captive
14 there while they're being dialyzed. So I'm interested
15 in that.

16 I think we should emphasize somewhere in the
17 chapter the business about transitioning from a dialysis
18 program to an end-stage renal disease program and point
19 to the disease management demonstration as another
20 important step there, Nancy.

21 The second thing I would say, though, is on
22 page 29 you -- I won't use the word admit, that's not

1 quite fair -- but you indicate that many of these
2 outcomes are influenced or can be influenced by both the
3 doctors and the dialysis facility. But it's not clear
4 to me after that that any of this quality money is going
5 to the doctors. It sounds like it's all going to the
6 dialysis facility.

7 And I've got to tell you, it's really all
8 about the doctor. I mean, it is really all about having
9 physicians who are understanding that these are very
10 important things and that there are new developments all
11 the time, and they're in touch with the patient.
12 They're getting a capitation fee on a monthly basis
13 already. They've been doing that for years. There's no
14 reason why, vis-a-vis what Alice says, there can't be
15 some additional quality payments in the capitation.

16 MS. RAY: We will work on the text to make
17 sure it is crystal clear that we are referring to both
18 dialysis facility and the doctors receiving a monthly
19 capitated payment.

20 MR. HACKBARTH: Should we include that in the
21 bold-faced recommendation?

22 MS. RAY: We can definitely --

1 MR. HACKBARTH: I think we ought to include it
2 actually in the language of the bold-faced
3 recommendation, that this applies to both the facility
4 and the physician.

5 DR. ROWE: You say it on 29 but then you talk
6 about providers. And to be fair, in the context of
7 every other document we've ever seen in this, provider
8 means dialysis facility.

9 MS. RAY: You're right.

10 DR. ROWE: So if I were representing the
11 nephrologists, I'd say let's be explicit.

12 MS. DePARLE: Jack made one of my points,
13 which was about the doctor. I guess in response to
14 Alice's point, and Nancy made this argument herself, I
15 think it is possible to do this. I don't think it's
16 easy to do it, especially when you also involve the
17 doctor. But I said last time and I'll say this time,
18 that I'm a little concerned about doing it on a budget
19 neutral basis given some of the data that -- now I've
20 been sitting here searching for it, Nancy, but I know
21 it's in here, about the GAO report recently about some
22 of the deficiencies in centers and CMS's neglect in

1 oversight.

2 MS. RAY: Right. I had mentioned that at the
3 December meeting. GAO issued a report, I think it was
4 in December, that specifically looked at CMS's and
5 state's -- their survey and certification efforts, how
6 well they're inspecting facilities. They found
7 deficiencies in that. However -- and, of course, they
8 suggested that CMS and the states improve upon these
9 quality assurance efforts.

10 he report also does make note that there has
11 been some improvement since GAO's report prior to this
12 one. So I think that's important to note, too.

13 And I also think the quality assurance
14 reflects Medicare ensuring minimal standards of care,
15 whereas the incentives as we've laid them out address
16 trying to improve quality of care. Both are important
17 aspects, clearly. And I think there are ways to improve
18 the quality assurance system, for example, having CMS
19 use intermediate sanctions and posting the data on the
20 compare website. MedPAC made recommendations on that.
21 And I think the incentives target a different angle of
22 quality, trying to improve the level and narrow the gap.

1 MS. DePARLE: I guess I was just surprised,
2 maybe I shouldn't have been. But I was surprised at the
3 level of deficiencies among some of the -- and the
4 percentage of centers that had them. And I don't think
5 we know. I think what you're saying is the oversight
6 may have improved. Frankly, that's a function of the
7 discretionary dollars that the Agency gets for survey
8 and cert, and they have to do annual nursing home
9 surveys and they don't have to do annual dialysis center
10 surveys. It's just that simple.

11 But given the levels of deficiencies, I just
12 have some concern -- it's a small amount, 1 percent of
13 payments. And if we believe that payments are adequate,
14 I suppose it's not that much. But I have a concern
15 about that.

16 MS. RAPHAEL: I remember in the text that you
17 sent us, Nancy, one thing that surprised me was that
18 margins and cost had no correlation with outcomes. In
19 fact, I think you indicated that the higher the margins,
20 the poorer the outcomes. I'm not sure I got that
21 correct, but could you just explain that because I think
22 it pertains to this issue.

1 MS. RAY: That was our analysis that we
2 published in our June 2003 report where we looked at
3 outcomes and providers' costs. And there we did not
4 find, with composite rate costs, we found little
5 association between higher costs and outcomes. We found
6 no significant association there.

7 DR. MILLER: So a facility might argue that
8 they have higher costs but then you're getting higher
9 quality. And that's why we went through this exercise
10 and we can't establish that relationship. That's part
11 of what makes us a little more comfortable with...

12 MR. HACKBARTH: Why don't you put the first
13 recommendation up? All opposed to the draft
14 recommendation? All in favor? Abstain?

15 Recommendation two. This will be amended as
16 we discussed to make specific reference to physicians.
17 All opposed? All in favor? Abstain?

18 Okay, thank you. Next up is Medicare+Choice.

19 MS. BURKE: Glen, just while people are coming
20 up. In the second recommendation the suggestion was
21 there was no cost implication. I thought I saw a
22 reference in the text that discussed that it might well

1 have some additional administrative costs. I'm not sure
2 that no is a fair representation.

3 MR. HACKBARTH: Sheila's making the point that
4 there will be an administrative cost attendant to
5 implementing the quality incentives.

6 MS. BURKE: Potentially.

7 MR. HACKBARTH: But we say it has no budgetary
8 effect.

9 DR. MILLER: Your point is well taken. A lot
10 of what we're doing when we do this -- and this is more
11 technical than we need to get into -- we're looking at
12 benefit baselines. But you're right, conceptually there
13 is an administrative cost.

14 MS. BURKE: And we ought to at least
15 acknowledge that.

16 DR. MILLER: I completely agree.

17 MR. HACKBARTH: Scott and Dan?

18 DR. HARRISON: The Medicare+Choice program has
19 provided the majority of Medicare beneficiaries a choice
20 of health care delivery systems through private plans.
21 Past MedPAC recommendations have supported that choice
22 and pushed for the choice to be financially neutral to

1 the Medicare fee-for-service program.

2 Congress has just passed legislation
3 establishing the Medicare Advantage Program for private
4 plans in Medicare. However, much of that program will
5 be based on the Medicare+Choice program. Thus, many of
6 the same issues for M+C will continue to be relevant.

7 One of the issues we have focused on is
8 setting M+C rates equal to what would be spent on
9 enrollees by the Medicare program if they chose to
10 remain in the traditional fee-for-service program. In
11 the recent legislation, Congress chose to increase
12 payment rates for 2004 and 2005 in order to bolster
13 plans to they would remain in the program until 2006
14 when some competitive factors would influence rates.

15 Remember last year payment rates were the
16 maximum of three prongs, a floor rate, blended local
17 national rate, and a minimum 2 percent update. For
18 2004, a fourth prong is added, 100 percent of the county
19 fee-for-service spending. MedPAC, of course, has been
20 recommending that all county rates be set at that fourth
21 prong. Adding the fourth prong and a few other
22 adjustments, such as restoring IME spending to the

1 rates, results in M+C rates growing faster relative to
2 fee-for-service spending.

3 CMS will release the actual payment rates for
4 2004 this coming Friday but just to give you an idea,
5 I've projected that M+C payments will average at least
6 107 percent of fee-for-service costs for demographically
7 similar beneficiaries and that's compared with 104
8 percent the past year in 2003. Those ratios do not take
9 into account any risk selection differences between the
10 plans and the fee-for-service program, and that kind of
11 difference will be discussed shortly.

12 However, given that Congress raised rates to
13 encourage plan participation and that legislation has
14 also given MedPAC several mandated studies involving
15 broad issues surrounding Medicare Advantage plans,
16 including a study due next year that will give the
17 Commission an opportunity to re-examine financial
18 neutrality. For the short run, including our report
19 chapter and the draft recommendations we discuss today,
20 we are focusing on other issues that are important for
21 the current program and that will also be important in
22 the long run.

1 I will present three draft recommendations.
2 The first two arise from the new risk-adjustment system
3 that has just been implemented. MedPAC has stated many
4 times that risk adjustment is crucial if we are to pay
5 private, risk-bearing plans properly. Risk-adjustment
6 can be used to help creative financially neutral
7 choices. CMS has made a choice in implementing the new
8 risk-adjustment system this year that has the effect of
9 moving away from financial neutrality and the first
10 draft recommendation would have CMS revert its position
11 in future years.

12 The new risk-adjustment system also present an
13 opportunity to expand plan choice to the ESRD population
14 and the second draft recommendation would take advantage
15 of that opportunity.

16 The final draft recommendation reflects an
17 extension of the Commission's analysis of using payment
18 incentives to improve quality of plan services.

19 CMS has implemented a new risk-adjusted system
20 just earlier this month. It measures risk using
21 demographics and diagnoses from inpatient, outpatient
22 and physician settings from the previous year. It will

1 greatly increase the accuracy of predicted fee-for-
2 service costs for M+C enrollees. And in 2005 a special
3 module will be added specifically for ESRD
4 beneficiaries.

5 MedPAC has recommended that risk-adjustment
6 systems be developed and used to pay plans fairly, both
7 compared with other plans and with the traditional fee-
8 for-service program. The new risk-adjustment system
9 will increase the accuracy of payments, paying plans
10 closer to the proportion of the expected costs of their
11 actual enrollees.

12 Thus, plans should be paid fairly compared
13 with competitor plans and should discourage plans from
14 devoting resources attempting to attract a favorable
15 selection of enrollees. However, all plans will be paid
16 more than it would cost the traditional Medicare program
17 to cover the same M+C enrollees because of an upward
18 adjustment that CMS is making for all payment rates.
19 CMS makes this adjustment to equalize total
20 Medicare+Choice payments under the new system with what
21 they would've been under the old demographic system.
22 All plans, regardless of the actual effect that the risk

1 scores would have on their payments, would benefit from
2 the upward adjustment. This adjustment directly
3 contradicts one of the prime reasons for risk adjustment
4 which was to pay the same to cover a beneficiary whether
5 the beneficiary enrolled in an M+C plan or chose to
6 remain in the traditional fee-for-service plan.

7 CMS has publicly committed to this policy only
8 through 2004. We do not know what the plan is for
9 future years at this point.

10 Which leads us to draft recommendation number
11 one. CMS should continue to risk-adjust payments with
12 the new CMS HCC system but should not continue to
13 increase payment rates to offset the overall payment
14 impact of risk adjustment. Because at this point CMS's
15 upward adjustment is not considered current law for
16 2005, eliminating it would not be considered a change to
17 the current law and that's why we have no spending
18 implications.

19 Medicare statute states that ESRD
20 beneficiaries are ineligible to join Medicare+Choice
21 plans. However, M+C enrollees who develop ESRD may stay
22 in their current plans. And CMS has exempted ESRD

1 beneficiaries who have had successful transplants from
2 the prohibition, it deems them eligible to join plans.
3 So at this point, the only ESRD beneficiaries deemed
4 ineligible are those that are receiving dialysis.

5 Given that the Commission believes all
6 beneficiaries should have equal access to managed care
7 options, and that CMS has developed and will implement a
8 suitable risk-adjuster in 2005, and that we have seen no
9 evidence that quality concerns are greater in managed
10 care plans than in for the fee-for-service for ESRD
11 beneficiaries, we present draft recommendation two,
12 which reiterates a recommendation that we made in 2000.
13 The Congress should allow beneficiaries with end-stage
14 renal disease to enroll in private plans.

15 One of Medicare's most important goals is to
16 ensure that beneficiaries have access to high-quality
17 health care. Generally, the current payment system is
18 neutral or negative toward quality and fails to
19 financially reward plans or fee-for-service providers
20 who improve quality. MedPAC has recommended that
21 Medicare pursue provider or plan payment differentials
22 to improve quality.

1 Applying incentives at the health plan level
2 serves several purposes. First, the health plan can use
3 purchasing leverage and data analysis capability to
4 encourage improvement by the providers with which it
5 contracts.

6 Second, health plans can also address the
7 problem of the lack of coordination and appropriate
8 management of chronic services across settings with
9 patients because they are responsible for all Medicare
10 services.

11 Measuring quality at the plan level may help
12 identify mechanisms for better coordination and thus
13 imparting lessons and may turn out to be useful in the
14 fee-for-service program, as well.

15 And to the extent that the plans approaches
16 are successful, providers who treat beneficiaries both
17 in the Medicare private plans and in the fee-for-service
18 program
19 may learn practices that improve the quality of care for
20 the fee-for-service beneficiaries they treat as well.

21 In last June's report, we developed criteria
22 for successful implementation of a financial incentive

1 program. As we noted in June, Medicare+Choice plans
2 meet all those criteria. Standard, credible performance
3 measures are collected on all Medicare+Choice plans.
4 Each year Medicare+choice plans report HEDIS data on
5 specific clinical process measures, for example
6 immunization and screening rates. And they complete a
7 survey called CAHPS that reflects health plan member
8 satisfaction with the plan's service provision. For
9 example, enrollees perceived ability to obtain care in a
10 timely manner.

11 Together these data comprise a widely accepted
12 broad cross-section of plan quality and most of the
13 measures in the data sets do not require risk adjustment
14 and plans have developed a variety of strategies to
15 improve upon their scores by working with providers and
16 their networks.

17 Going back a little bit to where we were with
18 Nancy, the goal of an incentives program should be to
19 improve the care for as many beneficiaries as possible.
20 Medicare could reward plans who meet a certain threshold
21 on the relevant performance measure or plan to improve
22 their scores or probably some combination.

1 In order to create incentives that would
2 improve quality for many beneficiaries, most plans would
3 need to feel that improvement goals were in reach.
4 Thus, we would favor rewarding a large share of plans.
5 The incentives would be financed with a small proportion
6 of total payments, as we just mentioned with dialysis.

7 What are some of the potential quality
8 measures that could be used? MedPAC uses the quality
9 goals outlined by the Institute of Medicine to determine
10 the level of quality of care provided in any setting.
11 Those are effectiveness, safety, patient centeredness,
12 and timeliness.

13 As mentioned, Medicare plans already collect
14 such data. These measures could be used in different
15 ways to create the payment incentives. Several of
16 individual CAHPS or HEDIS measures could be used to
17 focus on particular problem areas. The specific
18 measures could change over time to refocus plan efforts.

19 Individual measures could also be combined to
20 create more comprehensive or composite measures. We
21 don't really want to advocate any particular measures
22 but it is important to include all managed care plans in

1 the incentive system to maintain a level playing field
2 between plan types and to reward those plans that
3 invested in improving quality.

4 Incentive programs should thus use performance
5 measures that all plans can collect. All plans,
6 including PPOs and the private fee-for-service plans,
7 report on 12 of the 18 HEDIS clinical quality measures
8 and on all of the CAHPS measures.

9 However, for use in payment incentives
10 programs, we might favor relying more heavily on the
11 clinical measures of quality collected in HEDIS than on
12 the consumer satisfaction measures in CAHPS. The
13 Medicare payment system does not currently reward strong
14 plan performance on clinical measures, and although they
15 are publicly reported, the HEDIS measures do not tend to
16 influence enrollment decisions. Payment incentives tied
17 to clinical quality measures, however, do have the
18 ability to reward strong plan performance on those
19 measures.

20 In this draft recommendation MedPAC would not
21 be recommending any particular formulation other than
22 creating a reward pool from a small percentage of plan

1 payments and redistributing it based on plans'
2 performance attainment and improvement on quality
3 measures. The draft recommendation reads the Congress
4 should establish a quality incentive payment policy for
5 all Medicare Advantage plans.

6 MR. HACKBARTH: For the benefit of our
7 audience, although we are only considering
8 recommendations for incentive payments in two areas this
9 time around, M+C and ESRD, people should not infer from
10 that that we think that's the end of the task. We see
11 this as the beginning. We think this is a concept that
12 should be broadly applied within the program.

13 We've chosen the two areas of M+C and dialysis
14 because we think those are the two areas where we're
15 most prepared to move ahead, for all the reasons that
16 Scott and Nancy have described, consensus on measures
17 and the like. But this is not as far as we think these
18 concepts should be applied.

19 MS. ROSENBLATT: Are we going to discuss all
20 three or one at a time? Do you want me to make comments
21 on all three?

22 MR. HACKBARTH: Let's just do all three.

1 MS. ROSENBLATT: Scott, forgive me, I should
2 know this. But I'm getting confused about the years and
3 what you're recommending. The 4.9 percent is going to
4 apply to 2004 or 2005?

5 DR. HARRISON: [off microphone.] 2005,
6 although that number may change.

7 MS. ROSENBLATT: And is your recommendation on
8 not making this adjustment for financial neutrality, is
9 that started in 2005 or are you saying we shouldn't do
10 that in 2004?

11 DR. HARRISON: I think it's a little late to
12 say that for 2004, so we're focusing on 2005.

13 MS. ROSENBLATT: I think that maybe I'm not
14 the only one that might end up confused by the language.
15 And maybe if you could include that.

16 DR. ROWE: So it's 2005?

17 DR. HARRISON: Yes.

18 MS. ROSENBLATT: So that's my comment on the
19 first one.

20 On the second one, can you refresh my memory
21 because I remember at previous meetings the advocates
22 for ESRD patients have said don't do this. And I'm

1 trying to remember why they've said that.

2 DR. HARRISON: I think it tended to be more
3 from the dialysis facilities than from the groups.

4 MS. ROSENBLATT: No, I remember advocates.

5 MS. DePARLE: Alice is right. I met with the
6 advocates a number of times. There was a study going on
7 they wanted to see the results of before they were
8 willing to say it was safe.

9 DR. HARRISON: And I think we reported the
10 results of that study in June.

11 MS. DePARLE: I'm going back three or four
12 years.

13 MS. ROSENBLATT: So the advocates would now
14 say it's okay?

15 MS. DePARLE: Well, I haven't spoken with
16 them. But what they said then was that they just were
17 concerned that it might not be clinically safe for those
18 patients and they wanted to see the results of this
19 study.

20 MS. RAY: There was concern raised about the
21 quality of dialysis care in managed care plans versus
22 fee-for-service. CMS implemented a demo, started it

1 back in the late '90s, '97, '98, finished in 2001. An
2 evaluation was done on it. It included two plans,
3 Kaiser and a plan in Florida, ultimately, Health
4 Options.

5 The results of that showed that quality was
6 either the same or better in the plans compared with
7 fee-for-service on all the measures except one. The one
8 where there was a difference was on rates of kidney
9 transplantation. And that was with the Florida plan,
10 which was the much smaller plan in the demo. And that
11 was because of the distance from where the plan was to
12 the nearest transplant facility.

13 But on all the other measures that they looked
14 at -- and again, an outside group did the evaluation --
15 it was equal to or better.

16 MS. ROSENBLATT: On the third recommendation
17 I'm still hung up on this, if it was the private sector
18 you'd set up a liability. And I'm just wondering, you
19 all may think I'm crazy, but this is the actuary in me
20 speaking. Do we need some language, maybe not in the
21 recommendation. bit in the text that goes something like
22 this: as the actuaries and the trustees project the

1 long-range monetary obligations of the program, this
2 quality incentive needs to be considered in the long-
3 range financial projections. That it's not a zero
4 number, that there actually needs to be money included
5 in those projections.

6 DR. HARRISON: One way we had been thinking
7 about this is you could end up paying on relative rates
8 so that you pay for top X percent of beneficiaries in
9 plans. You stack up all of the scores and pay for the
10 top X percentage, so that you're sure the pot gets paid
11 out. But that was also confusing to people. So we'll
12 work on making it clear.

13 MS. BURKE: Alice, I would be concerned that
14 that kind of instruction would be translated into new
15 money and that's not, in fact, what's being discussed
16 here. We're talking about a zero sum game. We're not
17 talking about projecting an additional burden on the
18 trust funds, that the actuaries in calculating long-term
19 stability would consider.

20 MS. ROSENBLATT: I know, but we're not making
21 a comment about budget neutrality. So if they don't
22 include any kind of projection for this --

1 MS. BURKE: We could say that. I guess I
2 understood when you say set aside 1 percent, that's of
3 the existing pot, that is neutrality. That's not
4 additive money. That's out of the base.

5 MS. ROSENBLATT: But we don't have that. In
6 other words, I think where it exists right now is if
7 ends up being a half percent, we would be okay with
8 that.

9 MS. BURKE: That's not my point. My point is
10 it's out of the base; i.e., neutral. Maybe we need to
11 say that explicitly. Whether it's 20 percent set-aside
12 or a 1 percent or a third of a percent, it is out of the
13 base. It's not additive to the base. It's neutral to
14 the base. Maybe we need to say that.

15 MR. HACKBARTH: And it's our expectation, as
16 we discussed with the ESRD, that it will be paid out as
17 opposed to used as a mechanism to reduce payments.

18 MS. ROSENBLATT: I'd be a lot more comfortable
19 if we stated budget neutral.

20 DR. REISCHAUER: Scott, correct me if I'm
21 wrong, because I want to make sure Alice understands
22 this. A 4.9 percent across the board adjustment was

1 made for 2004 to payments when the new risk adjustment
2 procedures were introduced by an administrative action.
3 We are recommending not just that when the next tranche
4 of risk adjustment is introduced in 2004 that an
5 administrative action is not taken to add another
6 whatever percent to the payment, but that the payment
7 made for 2004 disappears, as it will disappear unless
8 the administration does something.

9 DR. HARRISON: It doesn't disappear in 2004,
10 it disappears forward.

11 DR. REISCHAUER: But in 2005 it would
12 disappear.

13 DR. HARRISON: Right.

14 DR. REISCHAUER: And there would be no
15 adjustment so we would be back to where we recommended
16 if be.

17 DR. HARRISON: This adjustment is not
18 published in the base rates. This is done sort of off
19 the books.

20 DR. ROWE: If we started at \$100 and we went
21 to \$104.90 for '04, what we would be recommending with
22 this is we go back for '05 to \$100.

1 DR. REISCHAUER: Right.

2 DR. ROWE: I have comments on each of these.
3 Let's start with the third one. Although I recognize
4 there's a lot of concern among health plans on the
5 quality issue, I believe in pay for performance and I
6 think we're generally trying to go in that direction and
7 I would support that recommendation.

8 As far as the end-stage renal disease -- and I
9 recognize this is budget neutral, not new money and I
10 would support that as well.

11 With respect to the end-stage renal disease,
12 I'm not too concerned the advocacy groups, so-called
13 advocacy groups who represent themselves as representing
14 the best interests of the patients. We heard a lot from
15 those groups about how it was really important to do
16 bone marrow transplants for breast cancer patients. And
17 I'd rather see what the data show, but unless the data
18 indicate that there's something wrong with giving
19 dialysis patients the option, I would support the
20 recommendation. As I read it it's voluntary. It's not
21 mandatory. So I don't understand why an advocacy group
22 might -- and you know, you've seen one dialysis patient,

1 you've seen one dialysis patient. They vary
2 dramatically from healthy young people with polycystic
3 kidney disease to elderly people with many diseases who
4 would benefit disease management programs and other
5 programs that might be in managed care plans.

6 So it would seem to me that we should let them
7 make that decision. And we might say some stuff about
8 that in the text about the variability of patients and
9 the disease management programs, et cetera.

10 Now on the first one, a couple points. One is
11 you started with the oft-quoted and sometimes striking
12 statement, Scott, about the payment rates from M+C
13 being, on average, 103 percent of fee-for-service
14 unadjusted and 117 or 113 of whatever it is adjusted. I
15 think it's fair, I liken this to the rural issue. It's
16 a little bit like talking about the payments to all
17 rural hospitals, including the critical access hospitals
18 and the sole community resource hospitals where the
19 rates were increased specifically in order to assure
20 access.

21 You take those out, then you see that the
22 rates for the rural hospitals don't look as high. The

1 numbers you gave us include the floor counties, where by
2 law the Medicare+Choice rates were increased above the
3 fee-for-service rates in order to assure access to
4 Medicare+Choice in the floor counties. So I just don't
5 think that's quite fair. I think you should take those
6 out.

7 You mentioned this in the text but in the
8 presentation that's what we lead with and that's where
9 everybody's starting point is. And everybody therefore
10 says well, these plans are being "overpaid." And I
11 think it's the same thing as with the rural hospitals.
12 It should be apples and apples.

13 That said, I think we have to then try to
14 figure out whether or not the difference between
15 politics and policy, as a wise person told me recently,
16 whether or not there was a policy reason for holding the
17 plans harmless during the transition or whether it
18 wasn't based on policy. I wasn't there, thank God, but
19 I guess the question is are we confident during the
20 transition in the first implementation of the risk
21 adjustment data and collection and analysis and
22 implementation that something bad isn't going to happen?

1 Presumably if there was a policy rationale, that was it,
2 to wait until this thing is in place. Does everyone
3 agreed that the data are what they are or are there
4 uncertainties about it?

5 This is a something I don't know much about
6 but other people do. So I'd like to hear something
7 about our degree of confidence about the implementation
8 of the risk adjustment.

9 DR. HARRISON: There is a transition built in.
10 This year it's 30 percent based on the risk adjuster.
11 Next year it goes to 50, then 75 and 100. So there is a
12 transition.

13 DR. ROWE: [off microphone.] I understand the
14 percent that's relative to the risk-adjusted data. I'm
15 just questioning what do we know how that's likely to
16 go?

17 DR. HARRISON: One of the problems is we don't
18 know. There hasn't been a statement as to why this is
19 being done and how long it would last. There hasn't
20 been a public commitment on the part of the Department
21 to know what their plans are.

22 DR. ROWE: We are taking a position contrary

1 to what Congress has recommended and CMS has publicly
2 said they're going to do; right?

3 DR. HARRISON: CMS has only said they're doing
4 it for '04. That's why we have this problem.

5 MR. HACKBARTH: We are reiterating a long-
6 standing MedPAC policy of neutrality, and that applies
7 in the case of the floors and all of the other reasons
8 that payments are elevated above fee-for-service levels.
9 I'm not sure I followed your first point on why we ought
10 to not include the floors in the calculation of the
11 relationship between M+C payments and fee-for-service
12 payments.

13 DR. ROWE: I didn't mean to imply that we
14 shouldn't have included it. I was just trying to get to
15 the point. I mean, if somebody comes up and says rural
16 hospitals are paid more than urban hospitals why X
17 percent, then somebody says wait a minute, that includes
18 these special hospitals where there was limited access.
19 And so they did that for a reason. And I think it's the
20 same thing with respect to some of these floor four
21 counties. So I'd just like that included in the
22 conversation.

1 MR. HACKBARTH: So what we're doing here is
2 we've increased the fee-for-service payments for rural
3 providers, elevating the Medicare fee-for-service levels
4 in the rural areas. And then we're saying on top of
5 that we are going to add still more money for private
6 plans. That's the policy that's in effect and that's
7 the policy that we're taking issue with.

8 DR. REISCHAUER: But Jack is suggesting that
9 the reason for the floors is to guarantee access for all
10 Medicare patients to Medicare+Choice plans. And I think
11 that was the original intent, but we have to remember
12 that this system, in a sense, has run amuck when you go
13 to Denver and you say that Denver County is a floor
14 county. I mean, I do believe that there are
15 Medicare+Choice plans in Denver, at least there were
16 when we were thinking of it as a site for an
17 experimentation because there was so much competition in
18 the area.

19 MS. BURKE: Just two questions on the actual
20 text. At the very beginning of the document you briefly
21 referenced the creation of the new Medicare Advantage,
22 or whatever it's called. I wonder if some fuller

1 explanation of how these differ from the
2 Medicare+Choice, because you suggest that they're
3 establishing a new program called MA, and that the MAs
4 are similar based on the rules and payment structure in
5 M+C, and M+C would become MAs.

6 For the ill-informed, some further explanation
7 as to is there really a difference or what the critical
8 differences are between what was and what will become
9 might be helpful.

10 DR. HARRISON: I don't think there's really
11 much of a difference except that they add the regional
12 plans.

13 MS. BURKE: I think a little further
14 explanation for people who haven't followed this closely
15 might be useful.

16 The thing I think that might be helpful in
17 terms of background information, the one chart that is
18 not included is the number of plans currently in the
19 program. You have the withdrawals and how many people
20 they affected. You don't have the number of plans
21 referenced, which the number of people is obviously more
22 critical. But there's also nothing in here, even though

1 you talk about the availability within certain areas,
2 you don't ever anywhere talk about how many plans there
3 actually are and how that has moved around, at least not
4 in the document I saw.

5 And I just thought for a fact, that might be
6 useful background to just have what the trends have been
7 and the distribution among the types of plans. You
8 referenced that in the content, in terms of how they
9 have changed but an actual chart that says how many
10 there are, how that's changed, and what the distribution
11 is across the types of plans might be useful as
12 background information.

13 MS. ROSENBLATT: Sheila, by plan do you mean
14 entity or do you mean like if one company offers five
15 plans it would be a count of five? Or would that be a
16 count of one for one company?

17 MS. BURKE: It would be a count of five. I
18 want to know how many plans are in play. If there are 5
19 million people enrolled, in how many plans are they
20 enrolled?

21 MS. ROSENBLATT: I would ask, I think both
22 might be helpful because you might offer five plans but

1 nobody takes four of them.

2 MS. BURKE: [off microphone.] I can't look at
3 this and say this many we talked about it. There's
4 nothing that references how many there are, how that's
5 changed and the nature against the types of plans.

6 DR. HARRISON: There's a problem with data in
7 that we know the only numbers that have been consistent
8 over the years have been the number of contracts which
9 is really a very tough measure of what --

10 DR. MILLER: Scott, just using the same metric
11 that we use to talk about plans dropping enrollment, we
12 will use that same metric to talk about what plans are
13 present and what the enrollment is.

14 DR. HARRISON: Yes, I have current
15 information. It's going back that's tougher.

16 MS. BURKE: [off microphone] Whatever we have
17 that's reliable in any way that is the least confusing,
18 but it's an obvious question that arises in the text and
19 there's no place where you actually figure out how many
20 of whatever is in play. But that in terms of -- and
21 also the explanation of [inaudible].

22 DR. NELSON: I agree with the recommendations

1 and basic principles. My comments are more second level
2 of detail.

3 I know we don't point out typos but
4 occasionally there will be a clinical reference that I
5 don't want to fall through the cracks and have us look
6 clinically ignorant. So on page 13 it references
7 hemoglobin levels for diabetes, and obviously mean
8 hemoglobin A1c levels. And I point that out just so it
9 won't somehow make it into the final report.

10 My main comment has to do with the
11 administrative burden, the hassle that comes from
12 abstracting information from records in PPOs or private
13 fee-for-service. You point that out on page 14 and you
14 point it out properly. But until we have an electronic
15 health record, it's really important for everybody to
16 recognize that simply rewarding these measures without
17 considering the cost in time and money to collect the
18 information and the fact that sometimes it's buried way
19 down in the chart where it's hard to find, the point
20 really needs to be borne in mind.

21 With respect to that, on table three, somebody
22 makes an allocation of which of these HEDIS reporting

1 data are applicable to private fee-for-service and PPOs
2 and which ones aren't. And a number of those are
3 arguable either way. For example: colorectal cancer
4 screening might be applicable because you have
5 colonoscopy and occult blood screening on administrative
6 data sets.

7 DR. HARRISON: This table is actually from the
8 Medicare managed care plan manual and this tells the
9 plan what they're responsible for. So indeed, PPOs and
10 private fee-for-service do report on the colorectal
11 cancer screening. Now actually, that one turns out to
12 be a new measure that they will have to start reporting
13 this year. So these are decisions that CMS has made in
14 administering the program.

15 DR. NELSON: Good. So that it doesn't become
16 arguable and attributable to us in that argument, let's
17 make sure that that's referenced.

18 DR. HARRISON: Let's make sure that that's
19 clear.

20 MS. DePARLE: Sheila's question reminded me of
21 a question I had when I read your materials. On page
22 five you talk about the private fee-for-service plans

1 and the reductions in those over the last couple of
2 years. And I was curious as to what we think is going
3 on there.

4 And then also you talk about the PPO demo. It
5 doesn't say in here but the goals of that obviously were
6 to expand access to these kind of plans. I can't tell
7 from this whether any of those demos have gone into
8 places where there were not already some sort of M+C
9 options.

10 DR. HARRISON: The answer is some but not
11 many.

12 MS. DePARLE: So how many?

13 DR. HARRISON: I did that a few months back.
14 My recollection is -- I don't remember. I think it was
15 single digits but I don't remember.

16 MR. HACKBARTH: Do you remember, Scott, the
17 percentage of the PPO enrollees that were previously
18 enrolled?

19 DR. HARRISON: Yes, that's in here.

20 MS. DePARLE: That's in here. That's 51
21 percent.

22 DR. HARRISON: There are some areas where

1 there wasn't a Medicare HMO where a PPOs went.

2 MS. DePARLE: That's what I'm more interested
3 in because if we want to get coverage of this in an
4 option for beneficiaries, if not why not? Maybe Jack or
5 others can answer, why are they still not going in
6 there? Are there other things that we need to be doing?

7 And on private fee-for-service, I'm surprised
8 that that seems to be declining and I'm interested in
9 any insights you have about why that's happening.

10 DR. HARRISON: My impression is they see their
11 history in an area. And if it doesn't look too good,
12 they get out. New plans, but I'm saying the one plan
13 tends to look at areas and see how they're doing.

14 MS. DePARLE: Loss ratios?

15 DR. HARRISON: I'm sure that's what they must
16 doing.

17 DR. MILLER: [off microphone] Also no
18 involvement.

19 DR. HARRISON: Well, their low enrollment sort
20 of generally. They have a very vast area and a no area
21 is their really large enrollment.

22 MS. DePARLE: Does it appear that there's any

1 relationship between the PPO demo and the retrenchment
2 of private fee-for-service? Because one could argue
3 there's similarities in what those two kinds of
4 offerings would be doing.

5 DR. HARRISON: I don't think so.

6 MS. ROSENBLATT: Scott, given Bob's comments,
7 I need some additional clarification. It's been pointed
8 out to me that there's report language in the Balanced
9 Budget Refinement Act of 1999 which reads as follows:
10 the parties to the agreement urge the Secretary to
11 revise the regulations implementing the risk-adjuster so
12 as to provide for more accurate payments without
13 reducing overall Medicare+Choice payments.

14 I don't know what that means, and for how many
15 years that was intended or whatever. I've just been
16 given that one sentence sort of out of context.

17 DR. HARRISON: I'm glad you found it because I
18 thought it was in BIPA. I couldn't find it last night.
19 So it's BBRA?

20

21 DR. REISCHAUER: That sounds like report
22 language. That isn't legislative language at all. So

1 it's sort of like don't complain to me when I vote for
2 this.

3 MS. ROSENBLATT: It was told to me that it was
4 report language, yes.

5 DR. HARRISON: What happened was originally
6 risk-adjustment was put in place. CBO, not knowing
7 exactly what was going into place, was reluctant to say
8 that there were any savings to it. So when it came back
9 with a zero score, Congress looked at it and said oh, so
10 you mean it's budget neutral? And then they put budget
11 neutral into the next report language. There were
12 questions about what the actual intent were and there
13 were two schools of thought about what the actual intent
14 was.

15 DR. WOLTER: I'm quite supportive of the
16 recommendation on the quality incentive, but a couple
17 observations. In my review of the HEDIS criteria, I
18 would say that's a pretty low bar in terms of
19 specifically the clinical quality indicators.
20 Particularly when you combine that with a recommendation
21 of collecting only what all plans normally collect, you
22 further even eliminate a couple of the clinical quality

1 indicators.

2 Looking ahead beyond this year into next year,
3 a few observations. I'm less optimistic than the
4 chapter would suggest that health plans will be good at
5 coordinating care because they're responsible for all
6 Medicare services. They're responsible for payment of
7 all Medicare services, but particularly plans that
8 primarily have panels made up of independent
9 practitioners may have less leverage than, for example,
10 Kaiser Permanente or other staff model plans.

11 Also, I would note that some of those plans,
12 Kaiser in particular, are making huge investments in
13 clinical information systems which may allow us to have
14 more immediate availability of the clinical quality
15 indicators.

16 The other thing I would say is that actually
17 in the fee-for-service system, CMS right now through the
18 QIOs is measuring a more robust number of quality
19 indicators than you would find in HEDIS. And in fact,
20 in the recent law we now have .4 percent of Medicare
21 payment actually tied to volunteer reporting of some of
22 those.

1 So there's kind of a lot happening all at once
2 right now and we might want to have our eye on how some
3 of these things could be brought into alignment as we
4 look at our quality agenda at MedPAC over the next year
5 or two.

6 For example, since many providers are going to
7 be capturing these measures anyway because of voluntary
8 reporting or QIOs, perhaps plans should look at their
9 quality agenda or we should be recommending HEDIS move
10 to including some of those same measures so that over
11 time we can compare plans with fee-for-service.

12 MR. DURENBERGER: First, I think this is an
13 excellent piece of work and an excellent start on a
14 subject that we're going be deeply involved in, much
15 more deeply involved in, in the future and so I thank
16 the staff for that.

17 Secondly, I very much want to associate myself
18 with Nick's remarks, and particularly that a plan is not
19 a plan is not a plan. But take it another step farther
20 and particularly my first question mark as I was going
21 through this was in the very first paragraph. And I
22 know the subject here is Medicare+Choice. It's not

1 docs, but it says Medicare has a strong history of
2 supporting private plans. The Commission strongly
3 believes that beneficiaries should be given the choice
4 of delivery systems that private plans can provide.
5 Private plans have a greater flexibility to innovate, et
6 cetera.

7 The implication is that you can't get a choice
8 of delivery system except through a plan. At least
9 that's one. And the second one is that plans have some
10 unique flexibility to innovate that provider groups in
11 particular do not. And that's not true.

12 You can go to Nick's practice group. You can
13 go to very large groups in North Dakota. You can go to
14 groups in Minnesota, Wisconsin, all over the country,
15 and you can find doctor groups who have done a lot of
16 investment in innovation, a lot of investment in
17 quality, and they haven't been rewarded for it because
18 the Part B system doesn't have a mechanism for doing
19 that.

20 So when we express ourselves in the context of
21 treating fee-for-service equal with private plans, et
22 cetera, I think we have to take it a step beyond that.

1 And part of what Nick said relates to that and part of
2 what I'm trying to say relative to this introduction
3 language is also important to say.

4 That is that groups of physicians, groups of
5 physicians and hospitals, systems like the one Nick
6 runs, which is a hospital systems but it's basically run
7 by a group of docks, but they run a hospital in a huge
8 service area, have traditionally done a lot of the
9 things that we are now turning nationally to
10 Medicare+Choice plans to try to achieve.

11 And I think each time we try to say MedPAC
12 supports this or that or we're fostering a particular
13 approach, we really do need to reflect the fact that the
14 system has failed, at least the payment system in the
15 past, has failed to reward a lot of docs and doc groups
16 in the fee-for-service system.

17 MR. HACKBARTH: I think that's an excellent
18 point and we need to treat the language. The benefit of
19 the M+C payment system is that it's a payment mechanism
20 that maximizes the flexibility of clinicians, provider
21 organizations to allocate resources new ways. Whereas,
22 the traditional fee-for-service payment system with its

1 silos can sometimes get in the way. Despite the fact
2 that the fee-for-service payment system gets in the way,
3 there are physician groups and provider organizations
4 who do it anyhow. We ought to know that that does
5 happen.

6 DR. REISCHAUER: I was just going to say, I
7 think this involves more tweaking than restructuring.
8 All you've said is that it's greater flexibility, not
9 that the others don't have any flexibility. And what
10 you probably want to say is on some dimensions, private
11 plans have greater flexibility. And then the list of
12 areas that you cited, some of those I think Dave right
13 would say, hey, a good practice group in Minnesota can
14 do that, too. But sort of the breadth of the benefit
15 package, financial services, some things like that, the
16 traditional fee-for-service system really doesn't offer
17 any ability to experiment or provide flexibility.

18 MS. RAPHAEL: Just to build on Nick's point,
19 I've recently been involved in a group working with
20 Kaiser and Group Health and others looking at this care
21 coordination and coordination across sites. And there's
22 just a lot of road to travel here. And I would like to

1 see looking at some outcomes that would measuring, in
2 fact, coordinating care across sites rather than again
3 just what you do within each of the components of the
4 providers that comprise the plan here. Because I think
5 until we begin to measure this, we're not going to see
6 movements even though plans ostensibly have more of an
7 incentive and they have control of the entire Medicare
8 dollar.

9 And then the other point, I see this as a
10 triangle with Congress, the plans, and the third angle
11 has to do with CMS. I don't think we're going to
12 succeed in this quality incentive area if CMS doesn't
13 build an infrastructure and change some of how it looks
14 at what it is responsible for.

15 I think we need to mention that in the text
16 because I think often something is passed and then lo
17 and behold we think about how is this all going to come
18 to pass.

19 I think there are some elements going on now
20 in CMS that can be built upon, but I think we need to
21 make that point ultimately for this area, for the ESRD
22 area, there has to be some attention paid to what's

1 going to happen in CMS.

2 MR. MULLER: To go back to Scott, your first
3 estimate I think when you started this, that you think
4 that the plans will be now be paid roughly 107 percent
5 of fee-for-service. Did I hear you correctly on that,
6 Scott?

7 DR. HARRISON: Yes.

8 MR. MULLER: And where we have some evidence
9 in the text that there's been some abatement in the
10 dropping, or at least the dropping of M+C enrollment has
11 dampened a bit, and in fact may have gone up by 1.5 or 2
12 percent in the last year or so; correct?

13 DR. HARRISON: Yes.

14 MR. MULLER: But if we have a payment plan in
15 which we're 103, 105, 107 percent above fee-for-service,
16 and we still don't have a major increase in enrollment,
17 one of the questions I have is how much is it going to
18 take to get enrollment back up? With a 7 percent
19 premium already, and I know some of that 7 percent is
20 perspective, but we've had more than 100 percent payment
21 the last few years and we've only had modest increases.

22 What will it take to get -- insofar as there's

1 a philosophical preference, at least as expressed in the
2 most recent legislation, for getting more people into
3 payment plans, whether it's flexibility or other kind of
4 reasons that the authors of the bill wanted, it's still
5 a fairly significant premium in light of all the payment
6 pressures inside the program.

7 I don't know whether we or anybody is yet
8 speculating as to what the increase might be. I
9 remember when Mr. Scully first came in, he was looking
10 to get M+C up to somewhere in the 30 or 40 percent
11 range. And obviously it went the other way for a while,
12 up to the recent abatement.

13 So I think one of the things we need to be
14 looking at, and I don't think it's part of our mandate
15 to speculate as to what it's going to take to get this
16 kind of increase. But certainly the evidence has been
17 that the payment increases have not brought the increase
18 in participation that people are looking for.

19 MR. HACKBARTH: I'm not sure that there's any
20 gain in our speculating about what the magic price might
21 be. There are a lot of factors at work in the market
22 here. I think a lot of Medicare beneficiaries were

1 stung either personally or heard of other people who
2 were stung by plan withdrawals. And it takes time for
3 people to get over that. All of the bad publicity that
4 managed care received in the 1990s, much of it if not
5 most of it unwarranted in my opinion, affects public
6 perceptions and affects enrollment rates. Lord knows
7 what the number is.

8 I think that's irrelevant. I think what's
9 important is the principle of neutrality. I strongly
10 believe, for a variety of reasons, that having this as
11 an option for Medicare beneficiaries is very important.
12 Jack gave us an illustration in the case of patients
13 with ESRD about the potential gains of being in a
14 private plan that has the flexibility to do some
15 different things. I believe that's true not just for
16 ESRD patients but for many other patients. I am a true
17 believer.

18 Having said that, I think it's critically
19 important that we be neutral. And I really don't care
20 what the right price is --

21 MR. MULLER: You misread my -- I'm in favor of
22 neutrality, too. We're paying a big premium to get

1 people in that goes well beyond neutrality.

2 MR. HACKBARTH: Let's be neutral and let the
3 chips fall where they may. The beneficiaries will make
4 their choices. Personally, I take a long-term view of
5 this. I think for a variety of reasons right now many
6 Medicare beneficiaries are discouraged about private
7 options. I think that will change in time. I hope it
8 changes in time because I believe it will be good for
9 them if the attitudes change.

10 DR. ROWE: Just one reaction. Those of us in
11 this industry are delighted that you're a true believer,
12 Glen. It sounds like you've drunk the Kool-Aid. It
13 doesn't sound like you're willing to pay for it, but it
14 does sound like you've drunk it.

15 [Laughter.]

16 DR. ROWE: I guess one thing I would say in
17 response to Ralph's question is that I think one way to
18 look at -- I don't know what the number is. That's not
19 worth thinking about too much.

20 But it is worth thinking about the floor
21 counties versus the others, or the rural areas versus
22 the others. Because what happens is Medicare determines

1 what the payment rate is for the providers and the
2 health plans negotiate. And in areas in which there are
3 thin networks, providers and hospitals, that drives up
4 the rates that those providers can charge and you wind
5 up with much higher than what the Medicare fee-for-
6 service payments are.

7 So that's like a whole bunch and if the
8 philosophy in Congress or CMS or in this room or
9 wherever is we want everybody in America who's a
10 Medicare beneficiary to try to access to a plan, that
11 one of the things that drives the numbers up. It's
12 those floor counties and the thin networks and the
13 marketplace. And I think that's what Glen was referring
14 to when he said there are a lot of market factors.

15 It's not a homogenous thing. It's very, very
16 different in large urban areas where there are
17 overlapping networks and Medicare payment rates are more
18 or less similar to what the plans might pay the doctors.

19 So I think that's just one issue to consider.

20 MR. HACKBARTH: I think you're characterizing
21 the reasons that people support these things accurately.
22 I believe it is because they do think that everybody

1 having access would be a good thing. And they think the
2 price lever is one lever that we can use to try to
3 stabilize enrollment and broaden plan participation. I
4 understand that. I respect that. But I do disagree
5 with it. I think it's a mistake for the program.

6 We need to move ahead with our votes. Do you
7 want to flash up our recommendations?

8 On draft recommendation one, all those
9 opposed?

10 MR. FEEZOR: [off microphone.] Question, this
11 is going to continue beyond 2004?

12 DR. MILLER: [off microphone] We're trying to
13 capture that with a should not continue.

14 MR. SMITH: [off microphone] I was troubled
15 by that language because it suggests there's another
16 payment increase in the offing. But what Bob was saying
17 is this payment should not continue. So I think we need
18 to reword.

19 MR. HACKBARTH: Does people understand the
20 intent here? All opposed? All in favor? Abstain?

21 Number two, all opposed? All in favor?
22 Abstain?

1 Number three, all opposed? All in favor?

2 Abstain?

3 Okay, thank you.

4 We'll now have a brief public comment period.

5 Please, as usual, keep your comments very brief. And if

6 someone ahead of you in line has made your comment

7 already, please don't feel obliged to repeat it.

8 MR. HAKIM: Mr. Chairman, my name is Ray

9 Hakim. I'm a nephrologist and also the Chief Medical

10 Officer for Renal Care Group, a dialysis provider. My

11 comments relate to the dialysis provision.

12 We very much appreciate the Commission's and

13 the staff's noting that we have improved outcomes in

14 certain areas, as Dr. Rowe has mentioned. They are

15 specifically in the dialysis program and not in the ESRD

16 program. But we appreciate that mention.

17 What perhaps may be important for the

18 Commissioners to realize is that this program has a

19 mortality rate of 25 percent. When I walk into the

20 dialysis unit, and when Jack Rowe was a famous

21 nephrologist, gainfully employed as a nephrologist,

22 every time I walk into the dialysis unit I know that a

1 year from now 25 percent of the patients will not be
2 there. And the issues related to that have been touched
3 on by a number of factors.

4 Clearly, it's not only high, it's higher than
5 breast cancer, colon cancer. And more importantly, the
6 mortality rate for the dialysis program in the United
7 States is much higher, between 50 and 100 percent higher
8 than it is in other industrialized countries.

9 So we have to ask ourselves what it is that we
10 here are doing or not doing. I agree with you that
11 attention to nutrition, attention to access factors, and
12 hopefully pre-ESRD, are issues that the Commissioners
13 will focus on.

14 But to think that this is going to be
15 happening in a budget neutral is illusory, because the
16 presentation by the staff that Medicare provider or
17 Medicare patients have a 2.7 percent margin is simply
18 not sustainable in our opinion. And we have presented
19 data to the staff about that.

20 The 2.7 percent margin has a 4 percent audit
21 factor established in 1996 and is nowhere representative
22 of the audits that we believe is important. I will

1 stand here next to you and apologize to the staff if
2 there is anywhere near 1 percent audit factor, let alone
3 4 percent. That's one issue.

4 The other issue is that this 2.7 percent is
5 based on cost reports that have limitations that have
6 not been addressed by the staff despite our
7 recommendations and suggestions to them. It has
8 limitations established in 1983 for medical director
9 fees, for administrative fees that simply are not
10 reflective of the true costs.

11 Third, there is also an implication that we
12 can improve efficiency and productivity. I will tell
13 you that there is probably a way in which we can improve
14 productivity. Right now we have one nurse for 12
15 patients. I suspect back in the office somebody is
16 calculating already can we do it one nurse for 15
17 patients. We have one dietitian for 100 patients.
18 Somebody is going to figured out maybe we can do one
19 dietitian for 125, 150 patients. So who's going to
20 suffer in that? It's the patients that are entrusted to
21 our care.

22 I would urge the Commission to really ask the

1 staff to focus on the audit factors, on this
2 productivity issue, and the true cost of providing care
3 because -- and I'm glad Dr. Rowe is back here -- we are,
4 and we have shown data, we are losing money on every
5 time we dialyze a Medicare patients when we include
6 drugs and everything else. And we have shown that data
7 to the MedPAC staff.

8 So I would urge the Commissioners to really
9 again challenged the staff to come up with a true audit
10 factor, a true efficiency factor, and a true cost report
11 factor.

12 Thank you.

13 MR. CHIANCHIANO: I'm Dolph Chianchiano with
14 the National Kidney Foundation.

15 I wanted to respond to Sheila Burke's question
16 about home dialysis patients and indicate that there
17 have been dramatic increases in quality indicators for
18 PD patients. We'd like to think that has to do somewhat
19 with the National Kidney Foundation practice guidelines.
20 From 1999 to 2002 there was an increase in the percent
21 of patients meeting the National Kidney Foundation
22 guidelines for weekly adequacy for dialysis. For CAPD

1 patients it increased from 55 percent to 68 percent and
2 there are similar patterns for cyclers patients.

3 I also wanted to address some of the comments
4 from Dr. Rowe about managed care plans and dialysis
5 patients and I wanted to explain why dialysis patients,
6 ESRD patients, remain skeptical about managed care. One
7 of the recent developments which I would like to bring
8 to your attention has to do with changes in copayments
9 that managed care plans have imposed. there was one
10 managed care plan that attempted to establish a \$50 per
11 dialysis treatment copayment a couple of years ago.
12 That would mean \$150 a week out-of-pocket for a dialysis
13 patient which would be impossible for most dialysis
14 patients.

15 The other concern is also financial, and that
16 is if a dialysis patient decides that they no longer
17 want to participate in a managed care plan, they will
18 not be able to get Medigap insurance to assist them in
19 their payment for their costs.

20 And then finally, with respect to the
21 demonstration project that Nancy referenced, take a good
22 look at the patient profile of those patients. And

1 also, I might note that one of the two plans that
2 participated was Kaiser and, which of course has a staff
3 model and it might not be applicable to the care of end-
4 stage renal disease patients in other managed care
5 plans.

6 Thank you.

7 MS. ZUMWALT: My name is LeeAnn Zumwalt. I'm
8 with DaVita, a national dialysis provider.

9 I wanted to be brief and support the comments
10 of Ray Hakim as to our economics. I wanted to directly
11 answer Dr. Rowe's question. The private sector does, in
12 fact, supplement and support the Medicare program.

13 On the access to care issues, we have provided
14 data to Nancy and to Mark Miller that says yes, in fact,
15 we are growing. But the data says where the growth is
16 is where the private patients are. We are not growing
17 in areas where Medicare is expanding and we're not
18 introducing new capital into areas that are
19 predominantly Medicare/Medicaid patient-oriented areas.

20 Thank you.

21 MR. JOHNSON: Good afternoon, Seth Johnson
22 with the American Association for Home Care. Appreciate

1 the ability to provide comments prior to the Commission
2 voting on recommending payment changes to the home
3 health benefit later this afternoon.

4 We urge the Commission to further study the
5 impact of the changes that have been occurring both
6 legislatively and regulatory-wise since the 2002 data
7 that is now widely available has been released.

8 We know that there's been some suggestions
9 today about the reliability of the data that is
10 currently available and we believe certainly that is the
11 case for the home health data that the Commission and
12 the industry and other government entities have been
13 looking at.

14 The industry did look at the profitability of
15 the Medicare home health benefit and it showed a
16 profitability of just over 5 percent based on 2002 cost
17 report information. The CMS home health market update,
18 looking at the profitability of the publicly traded
19 companies showed a 2.3 percent profit margin for the
20 home health industry.

21 We do know, based on the Commission's staff,
22 that over 1 million Medicare home health beneficiaries

1 are no longer receiving care that were receiving care
2 and that substitution is occurring. There's a lot of
3 changes that are occurring within the home health
4 benefit and the industry doesn't have all of the
5 answers, and I don't think anybody has all of the
6 answers as to what is truly occurring due to the issues
7 surrounding the availability of data that's reliable and
8 taking into account all the legislative and regulatory
9 changes that have been occurring.

10 We urge the Commission to not make any
11 additional changes to the Medicare home health
12 reimbursement prior to doing a complete and thorough
13 analysis of reliable cost report information.

14 Thank you.

15 MR. AUGUSTINE: My name is Brady Augustine and
16 I work as a senior advisor for the Administrator at CMS.
17 I'm also the senior person at the Agency for ESRD.

18 Dr. Rowe, I want to thank you for your
19 comments. I think the program has gotten away from its
20 intended purpose from 1973, and we're trying to bring it
21 back. We've taken a lot of activities, one example
22 given today is the disease management demonstration

1 project. Another one is in the recent statute, it takes
2 away the incentive to overutilize the separately
3 billable drugs.

4 So we want to take a more holistic approach to
5 care. A lot of the quality activities that are underway
6 presently in the dialysis industry are those for which
7 profit margins could be increased; i.e., anemia with the
8 use of Epogen. So we're trying to take away that
9 incentive to overutilize separately billables.

10 As well, we have also -- one of the reasons
11 why there hasn't been really good coordination in
12 holistic care for these patients is because all the
13 payment systems are not aligned. For instance, as you
14 referred to earlier, Dr. Rowe, the MCP -- and being an
15 old managed care person, any time you come up with a
16 capitation system where there are no accountability
17 requirements, it is potentially going to be abused.
18 Between the OIG and the GAO reports that we've received,
19 and also patient input into the Agency, the Agency
20 decided to make a change in the MCP and to require
21 physicians at least for in-center patients to see their
22 patients and provide a comprehensive assessment monthly

1 in order to get paid by the Agency.

2 So we're trying to get physicians involved.
3 We're trying to get facilities more involved. We have
4 this core court dataset initiative where I will admit
5 the industry has been quite helpful with the Agency in
6 submitting data to us on 100 percent of their patients.
7 As opposed to right now we just get a 5 percent sample
8 for the clinical performance measures project.

9 So we're looking to expand the data that we
10 get. We of course, are interested in outcomes-based
11 reimbursement for this program. And it doesn't
12 necessarily have to be before the fact. It could be
13 after the fact, depending on the evidence. For example,
14 with vascular access, there's such strong evidence that
15 proper vascular access care will lead to reduced
16 hospitalizations that depending on the evidence and how
17 we look at it, I would not have a problem paying above
18 what they're currently getting as long as we have the
19 evidence to show that we know there will be reduced
20 hospitalizations and will pay for itself.

21 So there are a lot of ideas bouncing around
22 the Agency. We're very interested in outcomes

1 reimbursement and getting everyone's payment system
2 aligned so that physicians and facilities are all
3 working toward the goal, which is patient-centered care.

4 Thank you.

5 MR. HACKBARTH: We will reconvene at 1:15.

6 [Whereupon, at 12:24 p.m., the meeting was
7 recessed, to reconvene at 1:15 p.m. this same day.]

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1 AFTERNOON SESSION [1:23 p.m.]

2 MR. HACKBARTH: Next on our agenda is the
3 payment update for physician services. Cristina, Kevin
4 whenever you're ready.

5 MS. BOCCUTI: Thank you. Our presentation
6 will be very quick today and it draws mostly on
7 information that Kevin and I presented to you last
8 month. Since we only have about five slides I'm going
9 to run through all of them but Kevin and I are both here
10 to answer your questions when I'm done.

11 Before presenting the draft recommendation and
12 as a backup I'm going to first mention some provisions
13 in the new Medicare legislation which affect payments
14 for physician services. Then I'll briefly review the
15 information we presented in last month's meeting on
16 payment adequacy for physician services and expected
17 cost increases for 2005. Finally, the draft
18 recommendation will be presented for your discussion.

19 So the first question you might have when you
20 see this slide is DIMA. This is what we're using now
21 for the Medicare Prescription Drug Improvement and
22 Modernization Act of 2003. I think that the acronym is

1 still in development but for today were using DIMA.
2 Other terms you might have heard are MPDIMA and MMA for
3 short, just the Medicare Modernization Act. So if you
4 hear them, we're all talking about the same thing.

5 So as you know, the new Medicare legislation
6 includes an update for physician services of 1.5 percent
7 for 2004 and 2005. This is going to be accomplished by
8 increases in the conversion factor. In addition to this
9 provision there are several others that will increase
10 payments for services furnished by fee-for-service
11 physicians.

12 The first one I'll talk about is the GPCI
13 floor. This is newly established in the legislation as
14 a floor of 1.0 for the work component of the fee
15 schedule's GPCI. So effectively this floor ends up
16 raising payments for services in areas with below
17 average costs of the work component.

18 Then the next is the scarcity bonus. Services
19 provided by physicians in newly-established scarcity
20 areas are going to receive a 5 percent bonus payment.
21 These scarcity areas are established separately for
22 primary care physicians and for specialist.

1 The third bullet there talks about a pre-
2 existing 10 percent bonus payment to physicians that are
3 practicing in health professional shortage areas. Under
4 the new legislation the responsibility for identifying
5 eligibility for the bonus will be shifted from the
6 physician to the Secretary, so that the payments will
7 become more automatic.

8 Finally, in Alaska all three GPCIs, that's the
9 work, the practice expense and the PLI GPCI will
10 increase to 1.67.

11 MR. DeBUSK: In the scarcity area bonus of 5
12 percent for primary care physicians and specialists,
13 will that include PAs and nurse practitioners as well?

14 MS. BOCCUTI: It's for the service. I think
15 that determining where it occurs was based on
16 physicians. So the bonus gets attached to the service
17 provided, but the areas are determined -- I think that
18 the determination was based on a ratio between the
19 physician and beneficiaries.

20 DR. HAYES: That's correct. I'm not 100
21 percent sure about whether nurse practitioners and
22 physician assistants are eligible for this thing or not.

1 I just don't recall from the legislation. We can get
2 back to you on that.

3 MR. DeBUSK: I can hardly see how they could
4 exclude them.

5 MS. BOCCUTI: We'll look at that. I think
6 that the health professional shortage areas might have
7 more latitude, but that's a good question. I'll
8 continue on.

9 As you know, MedPAC's framework for assessing
10 payment adequacy for physician services
11 relies on indicators of beneficiary access to physicians
12 and physician willingness to serve Medicare
13 beneficiaries. We draw on these indicators, among
14 others, because physicians don't report their costs to
15 Medicare as do other providers such as hospitals.

16 So I'll first talk about access. As we talked
17 last month and as we presented then in the last meeting,
18 survey data from 2002 and 2003 indicate that on a
19 national level beneficiaries have good access to
20 physicians and most beneficiaries are able to find a new
21 physician and schedule timely appointments. For
22 example, the largest survey that I presented last time

1 found that 90 percent of beneficiaries reported that
2 they were always or usually able to get doctor
3 appointments as soon as they wanted. But a small share
4 of beneficiaries report that they experience
5 difficulties getting appointments and finding
6 physicians.

7 In 2003, CMS sponsored a beneficiary targeted
8 particularly in areas where they thought beneficiaries
9 were most likely to have access problems.
10 Unfortunately, the study has not yet been released to
11 the public but we'll try to keep you updated on the
12 results of this study as possible.

13 The next bullet on the physicians supply up
14 there, the number of physicians practicing in the U.S.
15 has increased faster than both the general population
16 and the Medicare population. As we mentioned in last
17 month's meeting, survey data suggest that most
18 physicians are willing to accept new Medicare
19 beneficiaries but some do not. For example, the
20 National Ambulatory Medical Care Survey found that 93
21 percent of physicians with at least 10 percent of their
22 practice revenue coming from Medicare accepted new

1 Medicare patients.

2 As Kevin discussed in last month's meeting,
3 our examination of claims data through 2002 show that
4 the volume of physician services has continued to grow
5 steadily over several years and the steadiness of this
6 increase does not on its own indicated inadequate
7 payments. As you should recall also from last meeting
8 results from research sponsored by MedPAC show that the
9 difference between Medicare and private sector payment
10 rates, those payments widened slightly in 2002, a couple
11 percentage points. The driving force was likely the 5.4
12 percent cut in the fee schedule's conversion factor in
13 2002.

14 So the second part of our adequacy framework
15 looks at changes in cost for 2005. CMS estimates an
16 increase in input prices of 3.4 percent in 2005, which
17 is 2/10ths of a percentage point higher than its
18 estimate last quarter. The other factor that we
19 consider in our update analysis is productivity growth.
20 Our analysis of trends in multifactor productivity
21 suggests a goal of 0.9 percent.

22 So with all this in mind here again is the

1 draft recommendation for your consideration. It's the
2 same as we presented in the last meeting. The
3 recommendation would update payments for physician
4 services by 2.5 percent for 2005. This recommendation
5 would maintain current beneficiary access to physician
6 care and current physician supply for Medicare patients.
7 Our estimate indicates that this recommendation would
8 increase Medicare spending by somewhere between \$200
9 million and \$600 million relative to current law.

10 That concludes my presentation so we can
11 discuss it now.

12 DR. ROWE: On the proportion of the physicians
13 who are involved in the Medicare program you said it was
14 93 percent of physicians with more than 10 percent of
15 their patient revenues coming from Medicare were not
16 accepting new patients.

17 MS. BOCCUTI: Are accepting.

18 DR. ROWE: Were accepting; 7 percent weren't.
19 That could mean that they're too busy to accept any new
20 patients whether they're Medicare or not, or it could
21 mean that they're dissatisfied with the Medicare rates.
22 What percent of physicians do not participate at all in

1 Medicare who used to participate? That is, not the
2 pediatricians or obstetricians but people who actually
3 did participate and have dropped out.

4 MS. BOCCUTI: Let be clarify. Do you mean the
5 participation rate or actually seeing Medicare patients?
6 Because the participation rate is something where they
7 sign up and officially become a participant which has
8 some other value added to that.

9 DR. ROWE: Let me tell me why I'm asking and
10 then you can tell me which question to ask.

11 When there was a 5.4 percent reduction in the
12 physician payments we heard, hell, no, we won't go.
13 That we're going to withdraw from the Medicare program
14 and there's going to be a flight of physicians and there
15 won't be access, et cetera. So I'm trying to understand
16 whether or not there was. So that's my question, and
17 I'm not sure which of your subquestions that --

18 MS. BOCCUTI: I think I do. There was even an
19 issue when the cuts were scheduled that physicians were
20 saying, we're going to stop participating. CMS is
21 extending the time period when physicians could say
22 whether they're going to participate or not up until

1 February of this year. I think it's all related to the
2 conversion factor which was slated to decrease and now
3 is going to increase.

4 Now our analysis of the participation rates,
5 those are physicians who sign up to participate with
6 Medicare and thus can have a 5 percent -- their payments
7 per serve are 5 percent higher than those who are non-
8 participating. That rate has increased every year and
9 it's at about 93 percent I think this year, or 91
10 percent in 2003 and it has not dropped over the last few
11 years. It's in the draft chapter. I'm going to find it
12 for you.

13 DR. ROWE: What I'm trying to do and I'm not
14 doing it well is I'm trying to ask a multiple choice
15 question, not an essay question. How about if we pose
16 it this way? Do we have any evidence from the various
17 forms of participation that there has been any
18 significant withdrawal of physicians from the Medicare
19 program?

20 MS. BOCCUTI: Kevin wants to give it a shot.

21 DR. HAYES: We confronted that issue.

22 DR. ROWE: This is a yes/no question.

1 DR. HAYES: Then the answer is no. But let me
2 elaborate, if I may. I could elaborate a little bit but
3 if no is okay, maybe we'll just --

4 DR. ROWE: No, I don't want to take
5 everybody's time.

6 MS. BOCCUTI: Maybe we should just say when
7 we're looking at this on a national level.

8 DR. ROWE: Thank you.

9 DR. WOLTER: Just a question, in a table in
10 the body of the report, Table 3.b.3, if I'm interpreting
11 this right, the change in physician services per
12 beneficiary from year to year is basically a dollar
13 number because we're taking the RVUs and multiplying by
14 the conversion factor?

15 DR. HAYES: That's right.

16 DR. WOLTER: I'm wondering if it would also
17 have value to look at the change in actual units from
18 year to year, how many echocardiograms, how many CT
19 scans, because obviously some of them weight higher and
20 the dollar changes when it gets converted into a,
21 percentage. That might look differently than if we just
22 looked at the absolute numbers.

1 DR. HAYES: When we've done this kind of
2 analysis in the past we have often included the units
3 change as well. As you can see from this table it's
4 already got quite a few numbers in it so that's why we
5 chose not to. The other reason we chose not to in this
6 case was because we have found that the units changes
7 tend to be very similar to the changes that you see in
8 this table.

9 DR. MILLER: But we can put it in if you'd
10 like to see it.

11 DR. NEWHOUSE: Is it the all-services number
12 in that category that total the increase in RVUs? Does
13 that include the conversion factor change? about.

14 DR. MILLER: No, Nick is asking for just the
15 unit count, the number of services and what those
16 columns represent.

17 DR. REISCHAUER: The number of office visits
18 as opposed to the complexity.

19 MR. SMITH: Kevin, is the answer to Nick's
20 question that the average annual percentage change
21 column is a proxy for the number of units? That it's
22 very close?

1 DR. HAYES: It's similar to the number of
2 units, but it's weighted. The particular percentages
3 that you see in this table is weighted also by the
4 relative value units from the fee schedule. So it
5 captures not just the change in units but also any
6 change in the intensity of services that's provided.

7 MR. HACKBARTH: Any other questions or
8 comments?

9 MS. BURKE: Can I just ask for a clarification
10 on that? Does that suggest in the extreme that you
11 could have had -- showing a 9.4 percent change in echo
12 solely as a result of the intensity and not as a result
13 of the actual volume?

14 DR. HAYES: In the extreme, that is the case.
15 But as I pointed out to Nick, when we've looked at these
16 kinds of changes in the past we've seen some close
17 similarities between the number of units and the kind of
18 measure that you see here. But there's always the
19 possibility of the extreme case that you're talking
20 about.

21 MS. BURKE: We have no way to look at this and
22 know where it was largely volume as compared to

1 intensity?

2 DR. HAYES: The way to do that would be what
3 Mark was suggesting which is to put both numbers on the
4 table so you can do the mental subtraction one from the
5 other and figure out what's the intensity change.

6 DR. NEWHOUSE: I'm not following this, what
7 the table is then, because I would have thought that,
8 for example, when I look at imaging change 9.4 percent
9 between 2001 and 2002 that that was the increase in RVUs
10 for imaging. Then when we get down to a specific thing
11 like advanced CAT scan of the head 5.3 percent, I would
12 have assumed that was essentially almost all volume
13 because that's so specific. So I'm not sure what we
14 need that isn't in the table.

15 DR. MILLER: Both of your comments are
16 correct. That's why the actual raw volume count tracks
17 to this very closely because when you get down to this
18 level of disaggregation you are almost on a one-to-one
19 basis. But it really wouldn't kill us, we could put the
20 raw volume counts in with it. Just as long as everybody
21 is tracking this, you could count office visits and that
22 would be a straight measure of volume, or if more

1 complex offices visits were done, longer or whatever the
2 case may be, that could also drive this number up.
3 That's sort of volume and intensity. But they track
4 very closely I think is the point.

5 MS. BURKE: I understand what you're saying.
6 I'm trying to think of the implications for us in
7 greater clarity. It would seem that the implications
8 would simply be raising the flag if there were
9 disproportionate increases in volume of certain kinds of
10 activities that would then lead us to look at what is it
11 about that activity. Its it that there's something new
12 going on? Is it that it is overpriced? I mean, any
13 number of issues.

14 So the question is, does the specificity on
15 volume as compared to some suggestion there might be
16 some combined effect here give us more information that
17 would be useful in looking at the adequacy of the
18 payments by type of service? But what I hear you saying
19 is they track so closely disaggregating them may or may
20 not have any benefit to our understanding.

21 DR. REISCHAUER: I think there's enough here
22 to cause an eyebrow or two to be raised. That office

1 visits for establishment patients weighted by the
2 complexity should rise at 4.3 percent in one year you
3 think, drawn out over a decade what would this imply
4 about health care costs in America? Consultations 6
5 percent in a year. Some of these numbers seem very,
6 very high in areas that you don't expect there to be
7 huge procedure-type changes like imaging where imaging
8 is being used for things that it wasn't being used for
9 before.

10 DR. ROWE: Are these data corrected for any
11 changes in the patient population?

12 DR. HAYES: No, they're not.

13 DR. ROWE: Because we have this experience,
14 and I know in one year it's not dramatic, but that the
15 elderly are getting older and that the average age of
16 Medicare beneficiaries is increasing. There's a very
17 steep relationship between age and utilization.

18 DR. REISCHAUER: It's not increasing, I don't
19 think. As the baby boomers enter, the average age of
20 Medicare will fall.

21 MS. DePARLE: There are more old-old.

22 DR. NEWHOUSE: That's also true.

1 DR. ROWE: But the baby boomers aren't
2 entering yet. I'm the world's oldest baby boomer and
3 I'm 59. So as the baby boomers enter Medicare that will
4 happen, but we're talking about what happened last year
5 not what's going to happen in 2010. So I think that
6 with increases in longevity -- I'm just wondering that's
7 going to discount this number a little bit into if you
8 correct, that's all.

9 DR. NEWHOUSE: Medicare costs don't go up that
10 sharply because the medical care system isn't that
11 aggressive with the oldest old. They fall out at the
12 end.

13 DR. ROWE: I'm aware of those data. I was
14 thinking about number of visits. Those data are related
15 to hospitalizations and length of stay and stuff like
16 that, and people don't get hospitalize when they're
17 older. Not number of doctor visits.

18 MR. MULLER: What was the payment update in
19 '01, '02? Could this be one of those expenditure offset
20 type -- what did we call that, those days?

21 MS. BOCCUTI: You mean what was the actual or
22 what we recommended?

1 MR. MULLER: What was the actual payment
2 increase in '01, '02 for physician? Was that a cut
3 year?

4 DR. HAYES: Yes, minus 5.4 percent.

5 MR. MULLER: Insofar as there's been
6 speculation on expenditure offsets and so forth this
7 might --

8 DR. NELSON: But notice that the highest
9 category of those kinds of services was emergency room
10 visits which are largely patient initiated. They're the
11 ones that decide whether to go into --

12 MR. MULLER: I'm not suggested, Alan, it's
13 across the board because obviously the imaging ones are
14 technology driven, and we discussed this last year, the
15 price of the imaging devices has gone down considerably
16 therefore making the diffusion of them much more
17 possible. These used to be \$2 million tickets and now
18 you can get them for \$500,000, et cetera, and so forth.
19 So I think there's different explanations for different
20 parts of this but I agree with the point that either Bob
21 or -- these are pretty big numbers if you start
22 compounding them for ten years.

1 DR. MILLER: I'll just also remind you there's
2 been a couple of other discussions of volume growth
3 here. We went through, Kevin went through things when
4 we were disaggregating volume growth over a series of
5 years looking at imaging and different services and I
6 think you'll remember that. You were seeing
7 differential volume growth in different service
8 settings, and some of it fairly aggressive. Then we
9 commented on the AHRQ report on volume where they were
10 disaggregating it and trying to track to things like
11 change in demographics and those kinds of things and
12 they were finding that volume was growing in excess of
13 what those factors could explain, if I remember
14 correctly.

15 MR. MULLER: But one of the themes, Glenn,
16 that we've had cutting through our discussions for a
17 couple years now is looking at utilization and there's
18 all kinds of reasons why utilization is going up, will
19 go up, will probably accelerate. Not just the decline
20 of managed care, the technology, the aging. So
21 obviously a lot of what we think about here are payment
22 rates in our discussions, discourses, recommendations.

1 But I've been arguing for a couple of years now it's
2 utilization that's going to drive this even more than
3 the payment rates. And there's absolutely no break and
4 as I would say and I'm sure a lot of you agree, a lot of
5 accelerators on utilization inside our system and
6 there's nothing in sight to put a brake on that.

7 DR. HAYES: Just if I may, one more point on
8 that. We will have an opportunity to look more closely
9 at this issue of volume growth. The Medicare
10 legislation has a mandated study in it for us to look at
11 the volume of physician services addressing a number of
12 the issues that you brought up here today. That's due
13 in December of this year.

14 MR. HACKBARTH: Any other questions or
15 comments?

16 Okay, I think we're ready to move on to the
17 draft recommendation then. All opposed to the draft
18 recommendation which is on the screen? All in favor?
19 Abstentions?

20 Okay, thank you.

21 Next we have home health.

22 MS. CHENG: In this presentation I'll review

1 our evidence and discuss some new information in
2 response to questions that you raised at our December
3 meeting. I hope that I've addressed your concerns in
4 the draft chapter and the materials that we'll discuss
5 today. I'll start my presentation with a new
6 recommendation for your consideration in addition to the
7 recommendation that we discussed at the past meeting.

8 The idea of two recommendations is a pretty
9 important one here because I think we will find that we
10 have two issues on the table. One, is there enough
11 money in the system to adequately cover the cost of
12 providing care to Medicare beneficiaries? And two, are
13 the structures of the payment system making some
14 eligible beneficiaries less financially attractive than
15 others and possibly creating access problems?

16 I think we could find that there is enough
17 money in the system but at the same time certain types
18 of beneficiaries are less financially attractive than
19 others.

20 I'll start with the context for our
21 recommendations. Current law is market basket minus 0.8
22 percent to be implemented on January 1st, 2005.

1 Spending in 2003 for this benefit was \$10 billion. The
2 Congressional Budget Office projects that home health
3 spending will grow 17.7 percent in 2004 and continue to
4 grow at an average annual rate of 14 percent from 2005
5 to 2009 driven by continued growth in volume.

6 Another part of the context for making
7 recommendations in this benefit is that the definition
8 of this benefit is not clear. The benefit is not clear
9 because it's not bound neatly by the coverage described
10 in statute. By statute, the purpose of the Medicare
11 home health benefit must be the same as the general
12 purpose of all services covered by the Medicare program,
13 the diagnosis or medically necessary treatment of
14 illness or injury over a spell of illness.

15 However, precisely how the concepts of medical
16 necessity and spell of illness pertain to home health
17 care is less clear for this service than it is for
18 others. In home health there are no definitive clinical
19 practice standards to determine what treatments are
20 necessary and for what kinds of patients they are
21 appropriate. And the amount of service covered by the
22 home health benefit for those who are eligible is fairly

1 broad. It includes the skilled services necessary to
2 treat patients, nursing and therapy, as well as
3 ancillary, non-skilled or non-medical services that are
4 necessary in conjunction with those skilled services to
5 maintain the patient's health or facilitate their
6 treatment.

7 However, unlike other services where the range
8 of services is fairly broad, there is no explicit spell
9 of illness for which Medicare coverage applies.
10 Instead, coverage relies on eligible criteria, whether a
11 beneficiary is homebound, has a medical necessity for
12 care, and needs care on an intermittent or part-time
13 basis. However, here too the definitions of homebound
14 and medical necessity are not explicit. Coverage
15 decisions are made on a case-by-case basis by
16 intermediaries who do not have clinical guidelines nor
17 precise definitions of the criteria to work from. So as
18 a part of the context for our discussion we're going to
19 have a certain amount of ambiguity.

20 At our past meeting my presentation and
21 materials were focused on aggregate measures, especially
22 cost and beneficiary access. However, aggregate

1 payments may be greater than aggregate costs and many
2 beneficiaries may have access while the structures of
3 the prospective payment system inappropriately encourage
4 providers to serve some types of beneficiaries and
5 discourage the services of others. The decline in use
6 from 1996 to 2007 certainly suggests that we should be
7 on the lookout for structural issues. The changes that
8 were made in the mid '90s were intended to reduce
9 spending and use of the benefit but not to exclude any
10 group of eligible beneficiaries.

11 We also have evidence that there was a
12 disproportionate decline in use among some types of
13 beneficiaries. If some types of eligible beneficiaries
14 have been excluded from the benefit because of the
15 structure of the payment system then the system needs
16 structural change and we should be on a track to look at
17 whether there should be structural change.

18 We already know that three factors interacted
19 to precipitate the decline in use. The Secretary
20 initiated Operation Restore Trust in an effort to reduce
21 fraud and abuse. It prompted the involuntary closure of
22 hundreds of agencies that were not in compliance with

1 the program's integrity standards and established civil
2 liabilities for physicians who knowingly falsely
3 certified the eligibility of a beneficiary. Through the
4 investigations in Operation Restore Trust the Secretary
5 found that fraud and abuse was not uncommon during the
6 peak years of use.

7 Changing eligibility also had an impact on
8 use. In 1997, the BBA clarified the acceptable
9 frequency of visits and removed the drawing of blood as
10 a qualifying service. Agencies reported that changing
11 those eligibility criteria to exclude the drawing of
12 blood decreased the number of users significantly in at
13 least six high-use states. By defining the term part-
14 time or intermittent the BBA narrowed its coverage of
15 very frequent or nearly full-time care.

16 Changes in the payment structure also
17 contributed to the decline. When Congress changed the
18 law in BBA '97 and HCFA and CMS implemented those
19 changes the new structures changes favored short-term
20 recovery care over long-term maintenance care. The
21 payment system gives a heavier weight and hence higher
22 pay to providing therapy as compared to skilled nursing

1 or aide service and is neutral towards the presence of a
2 caregiver in the home.

3 Though decreasing use through reducing fraud
4 and abuse or decline in use that followed a change in
5 eligibility would not be cause for alarm, we should not
6 be sanguine about the 1996 to 2000 decline because
7 structural change may have made some beneficiaries less
8 financially attractive which could have impeded their
9 access to care. MedPAC conducted two studies to
10 determine whether the general decline in use was
11 accompanied by the exclusion of certain types of
12 beneficiaries. In both of our studies we focused on the
13 characteristics of beneficiaries in 1996 as the peak
14 year and then compared them to beneficiaries who used
15 home health after the large decline in use.

16 In our first study we could not identify a
17 particular type of beneficiary that had been excluded
18 from the benefit. Rather, almost every type of
19 beneficiary used home health care in 1996 and to some
20 extent still used home care in 2001. So instead we
21 looked at the likelihood of beneficiaries using home
22 health care and then compared it to the likelihood of

1 similar beneficiaries using the benefit in 2001. What
2 we found was that those with a clear need for the
3 benefit, which is to say that many or most beneficiaries
4 of that type used home health care in '96, those types
5 of beneficiaries had the smallest decline. Those with a
6 less clear need, which is to say some of the type of
7 beneficiary used home health but most did not even
8 during the peak years, that group had the greatest
9 decline.

10 We found mixed results in our second study.
11 Two types of patients who may be less financially
12 attractive were not disproportionately excluded from the
13 home health benefit during the period of decline in use.
14 Between 1996 and 2000 the average age and the level of
15 functional disability of patients increased. These
16 trends suggest that the older-old and the functionally
17 limited were still using the benefit after the period of
18 decline.

19 On the other hand, we found that the
20 proportion of users who did not have a caregiver fell
21 over this period. That latter finding is consistent
22 with a decline in the number of home health aide visits

1 provided by home health agencies. Because of the
2 heavier weight given to therapy and the neutrality of
3 the payment system toward the presence of a caregiver
4 the types of beneficiaries who experienced
5 disproportionate declines may be those who are less
6 financially attractive.

7 So is structural change needed? I think that
8 based on the evidence we have we have some mixed
9 signals. Home health agencies may be serving fewer
10 beneficiaries because of changing eligibility or program
11 integrity oversight. If so, then neither changing the
12 base payment nor the structure of the system would
13 increase use. Alternatively, they may be avoiding some
14 types of patients because they anticipate a substantial
15 loss on those types of patients. Making a structural
16 change by improving the outlier policy may improve
17 access for this type of beneficiary, and we are studying
18 the outlier policy.

19 Another explanation may be that they are
20 avoiding some types of patients because those types are
21 simply less profitable than other types. Now every
22 prospective payment system is built on the assumption

1 that some patients will be more profitable than others,
2 otherwise we would have a cost-based system. But if
3 subgroups of patients cannot get care or the providers
4 who do care for them are disadvantaged by caring for
5 them then a structural change would be necessary.

6 So to follow this track, MedPAC will examine
7 the structure of the payment system. We're going to
8 look at the relationship between case mix and the
9 financial performance of agencies. We're going to
10 analyze two large demonstrations which broaden the
11 homebound definition. We're going to extend our
12 analysis of changes in the characteristics of home
13 health users, especially their Medicaid status, their
14 level of cognitive impairment, and their behavioral
15 health issues. We're also going to study the outlier
16 policy.

17 These additional steps also are necessary.
18 The Office of the Inspector General will continue to
19 monitor access to care for beneficiaries following
20 hospitalization. CMS should continue the CAHPS survey
21 as an important part of monitoring all beneficiaries
22 access to care. And the Secretary should continue

1 efforts to identify similar patients across post-acute
2 settings and compare their use of care.

3 So on this track to pursue our concerns about
4 beneficiaries who may be less financially attractive we
5 come to draft recommendation one. The Secretary and
6 MedPAC must continue to monitor access to care, the
7 impact of the payment system on patient selection, and
8 the use of services across post-acute care settings.
9 Because of the exploratory stage of this recommendation
10 I cannot quantify it's spending implication and at this
11 point neither can I quantify the implications for
12 beneficiaries and providers.

13 DR. NEWHOUSE: Sharon, since we're just
14 monitoring why are there any spending implications or
15 beneficiary implications? Those implications would
16 arise if we did something based on the monitoring.

17 MS. CHENG: That's right. We could say none.

18 DR. WAKEFIELD: I don't recall that we've
19 included references to MedPAC in other recommendations.
20 Is there a reason why we feel compelled to recommend to
21 ourselves here, rather than just making a recommendation
22 to the Secretary? We assume that we're going to do this

1 anyway, but why --

2 MR. HACKBARTH: I think you're right, Mary, so
3 let's drop the reference to MedPAC. So we'll express
4 our intent in the text by what we do. Good point.

5 MS. CHENG: On our second track then, we will
6 consider evidence regarding aggregate payments and
7 costs. Our first factor is beneficiaries' access to
8 care. We found that most communities have a Medicare-
9 certified home health agency. 99 percent of all
10 Medicare beneficiaries live in an area that was served
11 by least one home health agency in 2003. Most
12 beneficiaries can obtain care when they seek it. Nearly
13 90 percent of beneficiaries surveyed about their
14 experiences in 2000 reported they had little or no
15 problem with accessing home health services. That
16 percentage remained essentially the same in 2001 and
17 2002. The comprehensive geographic coverage and low
18 rate of access problems suggests that access, in the
19 aggregate, for most beneficiaries is good.

20 The next pieces of evidence that relate to
21 whether aggregate payments are right are changes in
22 volume. One measure of volume is the number of

1 beneficiaries who use home health. Between 1996 and
2 2000 you can see the decline in the number of users. As
3 time passed without major changes to the payment system
4 the total number of beneficiaries using the benefit grew
5 for the first time in several years between 2001 and
6 2002. Both the Congressional Budget Office and the
7 Office of the Actuary at CMS project that use will
8 continue grow.

9 MR. HACKBARTH: Sharon, could you say just a
10 little bit more about that? On what basis are OAC and
11 CBO projecting that? Do you know what their thinking
12 is?

13 MS. CHENG: They have a similar set of
14 assumptions. They're not entirely aligned. In CMS's
15 most recent report they noted that changes made to the
16 homebound definition in one of the most recent pieces of
17 legislation could lead to an increasing eligibility.
18 They both note that the characteristics of the Medicare
19 population would lead to higher use if the rate remained
20 the same. They also see that there will be a growth in
21 the number of episodes per beneficiary.

22 MR. HACKBARTH: I remember seeing in the early

1 part of your presentation that CBO's projecting of an
2 average annual increase in expenditures of 14 percent
3 allowing a little bit for growth in the beneficiary
4 population and a little bit for updates is in there.
5 That's implying a fairly substantial increase in volume.

6 MS. CHENG: That's right. When we look at
7 some other measures of volume we see volume actually
8 starting to stabilize in 2001. Between 2001 and the
9 beginning of 2003, the number of episodes per
10 beneficiary remain the same, visits per episode decline
11 only 1 percent and the average length of stay increased
12 slightly. Thus, I think that the last couple of years
13 suggest that the historically rapid changes are slowing.
14 We have just entered this phase of moderate change and
15 we should not try to extrapolate too far from what we've
16 seen but it does seem to suggest that the phase of
17 agencies rapidly reducing the services they provide
18 within an episode is ending to be replaced by smaller
19 changes.

20 The reduction in the volume of services was
21 anticipated by CMS and GAO as the PPS was being
22 developed. Both groups stressed the need to monitor the

1 quality of care to determine whether the changes were
2 improvements in efficiency or stinting on necessary
3 care. MedPAC worked this summer to look at quality
4 changes. The work we did with our contractor, Outcome
5 Concept Systems, is parallel to the work by the Agency
6 for Healthcare Research and Quality in their national
7 health care quality report and to CMS's Home Care
8 Compare.

9 To get a complete picture of quality at the
10 agencies and to be consistent with CMS and AHRQ we
11 included patients with Medicare primary payer as well as
12 those with Medicaid. Scoring outcomes for home health
13 is very new so we don't have much of a context by which
14 to judge what the right score is. However these scores
15 provide a baseline and allow comparisons over time. The
16 median score for this quality index was .0.7 in both
17 periods. The average outcome score rose slightly and
18 the variation narrowed. Because we used all records for
19 all patients to derive these scores we can conclude that
20 the differences between those years were real and were
21 not caused by sampling.

22 We could conclude that quality has remained

1 stable at a good level. For example, in 2002 for every
2 clinical and functional indicator that we looked at such
3 as shortage of breath or ability to move around, at
4 least twice as many patients improved as declined, and
5 sometimes three or four times as many. There was also
6 improvement between the two years as the rate of
7 emergent care and unplanned hospitalizations declined.
8 However, on some measures there is room to improve. The
9 number of patients who did improve as a percentage of
10 those who could improve was less than 30 percent for
11 five out of 20 measures in 2002.

12 The stability of this score has some
13 implications for assessment of payment adequacy. There
14 were concerns that as agencies reduce the number of
15 visits they would cut out visits that were necessary to
16 achieve quality outcomes. Instead we observed that the
17 decline in the number of visits is concurrent with
18 stable adjustable quality.

19 MR. DeBUSK: Overall, the prospective payment
20 system for home health is this real successful? Is that
21 the general opinion that the OASIS assessment system and
22 all this?

1 MS. CHENG: I think there are a lot of people
2 who are still looking at this. We're only three years
3 into the system and as far as data we're maybe one or
4 two years into the system. So I guess I'd rather call
5 most people's opinions tentative than conclusive.

6 The next piece of evidence that we consider
7 are costs over the coming year. The market basket for
8 home health for 2005 is 3.3, and that market basket
9 reflects the increases prices of transportation, nursing
10 wages, and other inputs that affect the cost of
11 providing an episode of care. Even though input prices
12 have been rising over the past several years, the cost
13 of producing an episode has fallen recently and there is
14 no evidence that appears to suggest that costs increase.
15

16 We cannot disentangle the separate impacts of
17 changing product of productivity, but we have estimates
18 of their combined effect. Cost per episode fell 16
19 percent from 1999 to 2001 as the number of visits per
20 episode was reduced by half. The rate of decline in the
21 number of visits per episode continue at a much slower
22 pace from to 2001 to 2002 but our 2002 sample of cost

1 reports indicates that costs per episode continue to
2 decline at 1 percent between those two years. Over the
3 coming year we expect the slow changes to continue and
4 do not expect costs to rise.

5 MR. HACKBARTH: Let me just make sure I
6 understand the last part. Last year when we were making
7 this decision we just had a partial year, 2001, partial
8 sample of the 2001 cost reports which was a problem that
9 we struggled with. So now we have the full year of 2001
10 and part of 2002?

11 MS. CHENG: Right.

12 MR. HACKBARTH: And when you look at the
13 actual costs reported there there was a decline in costs
14 per case from '01 to '02?

15 MS. CHENG: That's right. It's only one year.

16 DR. WOLTER: I had a question on this point
17 too, because also in the body of the paper you talk
18 about increased productivity. But I'm wondering if it's
19 possible that the patient population or the product
20 change is more the driver of the cost improvements as
21 opposed to productivity in the traditional sense.

22 MS. CHENG: Absolutely. That's why in this

1 setting I haven't tried to pull apart product change and
2 estimate that and then productivity and try to estimate
3 that. What I'd rather do is just go with what I can
4 observe and say some it's been product change and some
5 of it's been productivity.

6 DR. NELSON: Kind of on this point because it
7 has to do with product change. Sharon, first would it
8 be useful to have some comparison between the kinds of
9 services that are provided by an agency to their
10 commercial business as compared to their Medicare
11 business? For example, are some entities excluding
12 certain Medicare patients from their services? It might
13 be that they will provide IV antibiotic therapy at home
14 for their commercial business but not for their Medicare
15 business because of differences in payment.

16 And are agencies accepting commercial business
17 with different payment policies than the PPS? Is there
18 still a lot of their business, their commercial
19 business, based on fee-for-service?

20 I think it would be really useful for us to
21 use the private sector as some comparison to reassure
22 ourselves that Medicare payment policies are

1 appropriate. Is commercial business a big part of most
2 agencies? Are there some agencies that don't accept any
3 Medicare business because they have ample commercial
4 business? And is the menu of services different
5 depending on the payer?

6 MS. CHENG: We can give that a shot. One of
7 the things that would make that difficult would be
8 trying to find a group of patients on the private side
9 that were comparable to the Medicare patients without --
10 we're not going to have a nice case mix adjuster over
11 for our private group. We do know that home health --
12 Medicare is built on a medical model of home health care
13 and a lot of the private services are home care. So
14 while there's certainly a medical component, there are
15 more home care components, light housekeeping, meal
16 prep, that are going to be mixed in. So you're going to
17 have a little bit of apples and oranges in trying to
18 compare those two groups, but we can see what's out
19 there to measure those two groups.

20 DR. NEWHOUSE: Would we have any information
21 about agencies that don't take Medicare patients?

22 MS. CHENG: I don't know where we'd get it

1 right off the top of my head.

2 MS. DePARLE: Otherwise all you have is who's
3 a Medicare-certified home health agency, who
4 participates in the Medicare program. Those numbers are
5 hard enough, as you point out in the chapter, about how
6 many are there, and how much changes there have been
7 since the BBA. That's very hard to pin down. But I
8 think the trade associations would have some sense of it
9 maybe.

10 MS. CHENG: The next factor in our framework
11 is a comparison of Medicare's payments and costs. In
12 modeling 2004 payments and costs we incorporate policy
13 changes that would into effect between the year of our
14 most recent data, 2001, and our target year, 2004, as
15 well as those scheduled to be in effect for 2005.

16 For the home health sector the 2004 estimate
17 includes all aspects of current law including a decrease
18 in the base rate that's scheduled for April 2004 of 0.8
19 percent. Our model generates a current aggregate margin
20 of 16.8 in 2004, a slight improvement since the first
21 full year of PPS. This margin suggests that the
22 payments are greater than the costs of caring for

1 Medicare beneficiaries. The distribution of margins
2 from 2001, our base year, indicated that 80 percent of
3 agencies had positive margins and agencies with positive
4 margins provided 82 percent of all episodes to
5 beneficiaries.

6 MS. BURKE: Could I ask a question on that? I
7 went back to the chapter because I didn't remember
8 seeing it so I don't think it's there. You can go to
9 the next slide where you have reflected the variation
10 between hospital-based and freestanding on a variety of
11 issues. What we don't see are the margin differences.
12 We see total margins for total delivery but not for
13 freestanding as compared to hospital-based. Do we have
14 that data?

15 MS. CHENG: We do. Our margins are based on a
16 complete set of freestanding agencies' cost reports.
17 When we looked at cost reports from hospital-based home
18 health agencies we estimated a margin around 3 percent.

19 MS. BURKE: I think that needs to be reflected
20 in the text unless there's a compelling reason not to.

21 MR. HACKBARTH: Here again we have our usual
22 issues about what does that mean and how the costs are

1 allocated between --

2 MS. BURKE: Right, but if we're going to array
3 all these other data points, case mix, visits, rural as
4 a percent, then I think we ought -- because the issue
5 will come up and has come up that in fact the margins
6 are different. I don't know what it tells us from a
7 policy perspective but it is a reality and it is a data
8 point, if we're going to reflect the others.

9 DR. NEWHOUSE: I think the implication of this
10 is that in fact it may be an accounting difference. I
11 took the thrust of the argument in the chapter to be on
12 other measures than the accounting measures they don't
13 seem to be that different or we don't see why they can't
14 be as costly. That was what I thought the implication
15 was, or the argument was.

16 MS. BURKE: Certainly the case mix appears to
17 be similar although freestanding seemed to be higher.
18 Episodes, rural they're predominantly -- the hospital-
19 based are predominantly rural. There's a variance there
20 and there's certainly a variance in terms of --

21 DR. NEWHOUSE: But let me put it another way,
22 you couldn't use these measures to account for a big

1 difference in margins.

2 MS. BURKE: I agree. My only point is it is a
3 factor. I don't know what it really means nor that we
4 should do anything about it. But to state that the
5 absolute of the margins are 16 percent when in fact --
6 and you do correctly, and I appreciate this, state that
7 that is based on the freestanding -- I think the obvious
8 question that arises is, all right, what is it for the
9 other 30 percent?

10 MR. HACKBARTH: I agree with that, so let's
11 put it in and then, along the lines of what Joe was just
12 saying, it's not evident from data like these --

13 MS. BURKE: Why there's a difference.

14 DR. MILLER: Can I just make one comment on
15 this? I apologize. What drove this whole thrust of the
16 analysis were a set of questions we got here in
17 December, and this comparison and all of that. I think
18 our feeling about this, and I know there is frustration
19 with this issue and we feel it as well. Our feeling
20 about this is that using the hospital-based margins from
21 the cost reports we get from the hospital are very
22 misleading.

1 MS. BURKE: I understand.

2 DR. MILLER: So we did this mostly to make the
3 point of they could very well be misleading. Some of my
4 reservations in listening to this is, if we're going to
5 get into the regular process of saying, this is what the
6 hospital-based home health margin is, I think that's
7 going to be -- I don't know if that's something we want
8 to do. The whole reason we do the all-of-Medicare
9 margin is because we don't believe the pieces of it.

10 MS. BURKE: I'm sensitive to that and I
11 appreciate that there are huge issues with these
12 numbers, not the least of which is the hospital cost
13 report and how one allocates costs and all the other
14 issues that are part of the whole debate about how one
15 considers margins. But my concern, Mark, is that in
16 this instance we affirmatively state a margin for
17 freestanding. We have one-third of the agencies are not
18 freestanding. It begs the question, having stated
19 affirmatively it is a margin for the freestanding,
20 what's the margin for the not? I know it brings all
21 those other issues and I'm happy to have it footnoted,
22 caveated, that the number is dog exhaust.

1 But the point is, it may not tell us anything
2 about how real the number is, or that we ought to do
3 anything about it, but I think to not state it leaves a
4 question.

5 MR. HACKBARTH: I agree with Sheila. I think
6 in terms of having our reports, coherent,
7 understandable, I think this adds to them. It's a
8 question. It's an obvious question. It's been asked by
9 commissioners. It's been asked by other people. Rather
10 than pretending it doesn't exist, we're better off
11 addressing it explicitly. Saying, here's the number --

12 MS. BURKE: And say the number is not a number
13 we're comfortable as really -- we can fully identify as
14 being accurate based on the issues that arise because of
15 cost reports and hospital-based activities. I
16 personally am not prepared to -- I'm not asking you to
17 do it so that I can then next time say, see, we ought to
18 have done something for the hospital-based. I know
19 you're fearful of that for good reason. Having stated a
20 number, the number is a discrepancy, people say, okay,
21 what's the story here? But I think not to state it
22 leaves the question out there.

1 DR. NEWHOUSE: I have an alternative proposal,
2 that we state it but we state a range that goes up to
3 something around -- then the freestanding, with the
4 argument that based on these data if one had some
5 numbers that didn't include the arbitrary allocations a
6 truer measure might be this. The case mix is actually
7 greater in the freestanding, which would suggest that,
8 if anything, the hospital margins might be greater than
9 the freestandings.

10 MS. BURKE: Right; one would think.

11 DR. REISCHAUER: But doesn't that depend on
12 what the payment is versus the case mix? The profit
13 margin maybe is larger for simpler things than for more
14 complex things.

15 DR. NEWHOUSE: But I'm assuming the case mix
16 is calibrated to approximate the cost or at least on
17 average is unbiased in these two entities. It may not
18 be but that's why I wanted a range. There's a lot of
19 uncertainty here, statistical. Just to put a point
20 estimate of whatever it is, minus three or plus three
21 for the hospital-based seems to me to be -- to really
22 mislead. It seems to me a way to get around that is put

1 in a range.

2 MS. BURKE: So, Joe, let me make sure I
3 understand your proposal. Are you proposing that for
4 hospital-based we give a range of, whatever the range
5 is, zero to three or whatever is, and for the
6 freestandings, similarly, we state a range that's X to
7 16?

8 DR. NEWHOUSE: Not the freestanding. Here's
9 the argument. The argument is that we have a number we
10 more rather than less believe for the freestanding. We
11 have a number for the hospital-based that we don't
12 believe, so if we just put in a number we would
13 basically say, here's the number but here's why we don't
14 believe you should attach any reality to this number,
15 which seems like a strange way to go. Instead of that,
16 if we're going to put in a number then say, but we think
17 a better number than this number is something that
18 approximates the freestanding number.

19 MS. BURKE: On what basis do we say that?

20 DR. NEWHOUSE: That's what I read as the
21 thrust of the argument or the implication of these
22 numbers.

1 MR. SMITH: No, the implication of these
2 numbers is the one that Sheila is suggesting, that we
3 don't trust the hospital number but given the cost
4 reports it is the number we have. We are comfortable
5 with the freestanding number.

6 DR. NEWHOUSE: The difference is both of these
7 agencies are providing a service out in the home. The
8 chapter makes that point so there's no particular reason
9 why costs should differ between hospital-based and
10 freestanding agencies other than these kind of factors.

11 DR. REISCHAUER: But let's imagine that 0.3 or
12 three actually was the right number for hospitals and we
13 have this freestanding entity that can do it a lot more
14 efficiently. We would not argue that we should pay
15 inefficient providers unless there's some particular
16 reason why this needed to be performed in a hospital,
17 which it isn't being performed in anyway.

18 DR. NEWHOUSE: That's also true. But the
19 problem -- we encountered the same thing on the SNF
20 side. So if we're going to maintain --

21 DR. REISCHAUER: But sometimes they're
22 imbedded --

1 DR. NEWHOUSE: But there the site of service
2 is the hospital in most cases. But still the general
3 burden of the argument is that the cost number -- when
4 you're allocating joint costs, costs don't -- what costs
5 are we after? Are we after incremental costs of home
6 health agency to the hospital? That's not the number
7 we're reporting.

8 DR. REISCHAUER: But I can make a case for why
9 hospital-based home health would be more expensive
10 because the labor agreement for nurses was part of a
11 larger structure, the administrative structure was more
12 complex and it's just a less efficient way of providing
13 something. It's interesting but it should drive our
14 payment policy.

15 DR. WOLTER: I would just say, it's kind of
16 the eye of the beholder. You could also look at this
17 data and say that since hospital-based have many more
18 rural agencies, they're lower volume and therefore the
19 overhead is higher per beneficiary leading to lower
20 margins. You could choose to make many different
21 arguments, but I think Sheila makes a good point. We
22 put the number in. We don't really know what the real

1 answers are today. But over time we probably due need
2 to address what some of the differences are.

3 MR. HACKBARTH: We do disaggregate the data
4 elsewhere, urban versus rural, and there's not a big
5 difference as I recall on an urban-rural basis. So that
6 wouldn't explain --

7 MS. BURKE: There is on volume.

8 MR. HACKBARTH: Volume is the more important
9 predictor. But even then the lowest volume are still
10 not as low as 3 percent.

11 MS. CHENG: No, they're 12.

12 MS. BURKE: But you could imagine
13 transportation -- I mean, there are a lot of issues that
14 presumably one experiences in a heavily loaded rural --
15 I don't know. I mean I don't know why they're different
16 and I don't pretend to believe that they're necessarily
17 accurate.

18 MR. HACKBARTH: So that's where I'd like to
19 leave this. I think that we ought to include the data.
20 We ought to explain why we're not sure that it's an
21 accurate number. In addition to that, I would like to
22 see us to make Bob's point that even if it were an

1 accurate number it shouldn't necessarily drive payment
2 decisions. So those are the basic points to include.

3 MS. CHENG: Within this context then using the
4 evidence that we've reviewed I think we come to this
5 conclusion on our second track. Congress should
6 eliminate the update to payment rates for home health
7 services for 2005. This recommendation would reduce
8 spending by \$200 million to \$600 million over one year
9 and by \$1 billion to \$5 billion over five years compared
10 to current law. We believe that the adequacy of
11 payments in the current year and over the coming year in
12 the aggregate suggest that there will be no major
13 implications for beneficiaries or providers.

14 With that I'd like to close my presentation
15 and turn it over for discussion.

16 MR. HACKBARTH: Any other questions or
17 comments?

18 I have a question and I guess it relates most
19 to the earlier recommendation about monitoring and
20 expressing concern about particular types of patients.
21 I need some help remembering how the case mix system
22 works. As I recall from the text, you say that patients

1 with less well-defined needs may be less attractive
2 financially because the system isn't adjusting for
3 factors like their functional status and cognitive
4 state. Did I remember that correctly?

5 MS. CHENG: Actually, their functional status
6 is a pretty big part of the case mix adjuster, but their
7 cognitive status, behavioral health issues are not a big
8 part of the case mix. So if those make the patient less
9 financially attractive they're not a big part of the
10 payment.

11 MR. HACKBARTH: What was the thinking behind
12 the decision to exclude factors like that from the case
13 makes adjustment? As a layman it seems like they may
14 well affect the cost of caring for these patients.

15 MS. CHENG: I think that part of the issue
16 when they were designing the case mix is that they were
17 trying to build a case mix adjuster that was intuitive
18 for the clinical practitioners in the field, and
19 especially for some of the cognitive problems and for
20 some of the behavioral problems there was a feeling that
21 some of the practitioners weren't as confident about
22 their ability to adequately assess a patient in the

1 home. A PT may be much more comfortable with his or her
2 ability to determine whether the patient has the ability
3 to move around rather than a cognitive impairment. So
4 part of that was, what was the consensus among
5 practitioners in the field that they could really
6 measure, that they could understand the care path for,
7 and that would be an intuitive case mixer. So there
8 were issues with some of those measures.

9 MS. RAPHAEL: Just to add to that, I think the
10 other part of it was thinking about tasks that you could
11 somehow concretize and capture and a rehab interaction
12 is easier to capture.

13 Now I think I made this point and I think it's
14 important and people should understand this, you could
15 have a lower case mix in the system today and consume
16 more resources. It's very, very possible and quite
17 common, because if you have cognitive impairments, if
18 you don't have a caregiver, then you have to put in more
19 service units although the case mix doesn't capture that
20 and you don't get paid for those additional units of
21 service. That's why it is also possible that if you're
22 in a market where you have higher demand than supply you

1 could be choosing the cases where the case mix index
2 better captures and rewards you for the provision of
3 service.

4 So I think that is important to understand in
5 all of this and it's why I support the need and am very
6 glad to see it's reflected here today, the need to
7 monitor access, the need to really step back, which is
8 entirely appropriate. When we put in this prospective
9 payment system we well understood that we were changing
10 some of the incentives here and that we had to come back
11 and modified it as we saw it implemented. So I think
12 those areas really need to be focused on.

13 The other point that I wanted to make is that,
14 I guess this is building on something that Nick said, I
15 don't know where we are on quality. I would not move to
16 say that quality is stable, because I don't think we're
17 caring for the same patient group today that we cared
18 for in 1999. So, yes, maybe rehospitalization,
19 unplanned rehospitalization and emergent care has gone
20 down, but that may well be because the number of
21 congestive heart failure and COPD patients have dropped
22 very dramatically, so therefore you're not getting the

1 same rehospitalization rates.

2 So I'm just not as comfortable saying that
3 quality is stable. I don't know that it hasn't improved
4 or that it's stabilized or it's decreased. I just don't
5 think we know enough at this point because it's very
6 much tied to the change in product and the change in the
7 patients that we're currently seeing.

8 DR. ROWE: Carol, it's very interesting about
9 the imperfections in the financing with respect to the
10 resource needs per patient, but let me see if I can
11 follow the logic because I'm not sure I get to the same
12 place you do.

13 If the conditions that are required for your
14 scenario are that demand exceeds supply, let's say there
15 are 120 Medicare beneficiaries and resources to take
16 care of 100 of them, and what you're saying is that if
17 the payments are such that people are going to
18 differentially avoid patients with dementia or something
19 because they're going to get paid less than what we're
20 going to have is 20 patients with dementia who didn't
21 get into home health and that's going to be a subset
22 that's easily defined.

1 But if that's not the case and if payment
2 system were perfect across all diagnoses you're still
3 going to have 20 patients who are Medicare beneficiaries
4 who aren't going to get treated because the defining
5 condition is demand exceeds, supply. You can only take
6 care of 100. But instead of all having Alzheimer's
7 they're going to have a variety of things. How are we
8 better off?

9 So it seems to me that, yes, it's true that
10 certain subgroups would be differentially disadvantaged
11 but for any given patient it's that given patient. And
12 the answer is that if demand exceeds supply then we
13 should change payments or something in order to try to
14 get a stimulus to get more supply.

15 DR. REISCHAUER: But there's one for
16 condition, and that is for the dementia patients you
17 have to be losing money if you take them on, not just
18 making less money than you would if you took on somebody
19 else. Then there's another question which you'd have to
20 ask under your scenario is, what keeps this industry
21 from expanding, if there is excess demand, when there's
22 a 16.8 percent margin here on average?

1 DR. NEWHOUSE: On Medicare.

2 MS. RAPHAEL: That's a good question, why
3 isn't there more entrants into the industry with this
4 kind of margin? I think that is a good question. I
5 would answer your question that I would increase my
6 supply because it then would be worthwhile for me to
7 perhaps pay more, et cetera.

8 DR. NELSON: Help me, Sharon, and perhaps
9 Carol, so I don't climb up a wrong tree here. Is there
10 any substantial risk of having payment policy create a
11 two-tier system in which Medicare patients get a
12 substantially inferior level of care in their tier? Or
13 is Medicare such a dominant payer within the home care
14 industry that that's not a concern? My comments were
15 directed toward whether Medicare is being disadvantaged
16 in competition with private business. I really don't
17 know. I don't know whether the risk of a two-tier
18 system is worrisome or not.

19 MR. HACKBARTH: On these facts, I don't think
20 you would be worried about that. It's the Medicaid
21 patient maybe that you would be worried about. But
22 Medicare is paying well.

1 DR. NELSON: Medicare is just fine?

2 MS. CHENG: In the financial analysts' papers
3 they routinely note that Medicare is the highest margin
4 payer in the industry.

5 DR. NELSON: Good. Thank you.

6 MS. RAPHAEL: The total margins I believe,
7 Sharon, are about 2.3 percent overall for the industry
8 when you put the payers together. The most difficult
9 subset are the dually eligibles or the Medicaid patients
10 who tend to fit more into the complex case or the need
11 for supportive care categories.

12 DR. NEWHOUSE: I want to go back to the issue
13 on margins by line of business at the hospital. Let me
14 make an argument that we basically don't want to present
15 those numbers in any of the products. So let's first
16 say for the sake of argument that we want to keep the
17 hospital in business as a multi-product firm. So this
18 is not the hospital that's failing. Then the issue is
19 either the total margin or what we've called the most-
20 of-Medicare margin. It's not the individual lines of
21 business. We can and weekend and should present those
22 numbers, and do.

1 Then when we now get to the product line we
2 want to say, do we want to keep the hospital in business
3 as a producer of whatever, home health, SNF, whatever?
4 Then if anything, the cost numbers that would be
5 relevant to that are the reverse of what we have in
6 reality. That is to say, if you start with the
7 assumption, which I think is reasonable, that the
8 inpatient service is the service that's there first and
9 these other services either are there or not there given
10 that the inpatient service is there. Then the issue
11 really is how much does it cost the hospital to add this
12 extra service at some scale of business?

13 Under those assumptions you would allocate the
14 joint cost to the inpatient side, and you would say it's
15 just the incremental cost of adding home health that we
16 should allocate to home health, and SNF, and so on. Now
17 in fact what we've got is exactly the opposite. The
18 hospital could push in as much of the joint cost as they
19 can out of the inpatient side. So I think, as I say,
20 the individual numbers are -- when we say we would like
21 the true number, there really isn't a true number unless
22 you go to this incremental definition which is far from

1 what we have or could, I think conceivably get.

2 Whereas, the most-of-Medicare margin I think
3 does have a meaning and the total margin has a meaning.

4 DR. ROWE: Are you suggesting that, therefore,
5 for the different, as you call them, the different
6 product lines, inpatient, outpatient, SNF, et cetera,
7 that we not show those that all?

8 DR. NEWHOUSE: Yes. I just don't think that -
9 - because it's inherently arbitrary where you put these
10 joint costs, unless you want to say, you should
11 basically put them over on inpatient, which is not
12 anything like the numbers we have.

13 DR. WOLTER: I'll try to be brief because
14 we're really not deciding this issue today I hope. But
15 I would really disagree with that argument, Joe.

16 Number one, I think each of the of the key to
17 the PPS systems is based on a system of averaging, but
18 they weren't designed to be blended together. Even
19 within one system we currently have DRGs that are quite
20 profitable and some that aren't, and there are decisions
21 being made in terms of strategy and product line
22 development based on that knowledge in the industry.

1 Similarly, we have other recommendations that
2 suggest that we want different sites of care for the
3 same thing to, roughly speaking, be given the same
4 payment. So if we're not even tracking what happens in
5 hospital outpatient, how do we have the discussions
6 about ASC? I think there are so many problems with not
7 charting a course in terms of our framework and
8 philosophy that addresses this issue, wherever we go,
9 that we could get ourselves into. But I think there
10 would be many, many reasons to continue to try to look
11 at the individual PPS system because that's how they
12 were set up.

13 MR. HACKBARTH: In addition to that, one of
14 the reasons why I don't think we can just whistle by
15 this one is that the issue is out there, even if we
16 don't choose to address it. For example, as I
17 understand it, one of the differences between the
18 industry's margin calculation and ours is that theirs
19 includes the hospital-based agencies and they pull down
20 the average with that.

21 I think we need to talk about this issue in
22 this chapter this year and if we, for all the reasons

1 that have been discussed, are skeptical about those
2 numbers, don't think that even if they were right they
3 would be the appropriate basis for payment policy, we
4 need to lay that out. So as opposed to just saying, it
5 shouldn't be there and we're not going to talk about it,
6 we've got to talk about it.

7 MS. RAPHAEL: I think that's really important
8 because the industry has done its own analysis and its
9 numbers are quite different from the numbers that MedPAC
10 has come up with. I do think we need to be able to
11 explain what those differences are.

12 MR. HACKBARTH: We need to move ahead at this
13 point so do you want to go to the other recommendation?
14 We'll make the editorial change suggested by Mary. All
15 opposed to this recommendation raise your hand. All in
16 favor? Abstentions?

17 Then on the update recommendation, all
18 opposed? All in favor? Abstentions?

19 Okay, thank you, Sharon.

20 DR. SEAGRAVE: Good afternoon. I will now
21 briefly review the evidence regarding SNF payment
22 adequacy for fiscal year 2004 and present the draft

1 update recommendation for fiscal year 2005. Since
2 you've seen most of this at previous meetings I will be
3 brief.

4 The evidence we have suggests that most
5 Medicare beneficiaries have access to SNF services but
6 that certain types of patients with special needs, such
7 as those who have diabetes, need ventilator support, are
8 morbidly obese, or who have special feeding requirements
9 may stay in the hospital setting longer before they go
10 to a SNF. We don't know if this is a good or bad
11 outcome for these patients. However, this finding may
12 point to problems with the distribution of payments in
13 the SNF payment system, and we'll return to this point
14 later when we discuss the second draft recommendation.

15 In terms of supply, the overall supply of
16 Medicare-certified SNF facilities and SNF beds appears
17 to have been pretty stable since 1998 with the total
18 number of Medicare-certified SNF facilities declining by
19 less than 1 percent between 1998 and 2003. As you can
20 see from this graph, the number of Medicare-certified
21 freestanding SNFs has grown pretty steadily since 1992.
22 This is the yellow line. The number of hospital-based

1 SNFs, however, peaked in 1998 and has declined each year
2 since.

3 From 2002 to 2003, the most recent data we
4 have, the number of Medicare-certified freestanding SNFs
5 grew by about 2 percent and the number of hospital-based
6 SNFs declined by 9 percent. Note that Medicaid-only
7 nursing homes, that is nursing homes that do not serve
8 Medicare SNF patients, are not included in this graph
9 because they are not relevant to our discussion. Their
10 numbers have been declining in recent years.

11 In 2001, the most recent year for which we
12 have data, the volume of SNF services grew with
13 discharges increasing by 6 percent, the number of
14 covered days increasing by 8 percent, and the average
15 length of stay increasing by about 2 percent.

16 Evidence regarding quality of care is mixed.
17 I want to pause here for a moment and discuss this a
18 little bit since it came up at the December meeting.
19 Most of the evidence we have regarding quality of care
20 in SNFs is from the year 2000 and before and much of it
21 comes from studies of overall nursing home quality
22 rather than quality of care in SNFs specifically.

1 Recall that about 90 percent of all SNFs are located
2 within nursing homes. We generally assumed that nursing
3 home and SNF quality are related.

4 Overall then, studies of patient care in
5 nursing homes have tended for many years to find room
6 for improvement in the quality of care delivered to
7 nursing home residents. In addition, some studies have
8 suggested that nurse staffing levels in nursing homes
9 declined and the number of reported deficiencies in
10 nursing homes increased between 1998 and 2000, the years
11 immediately following the SNF prospective payment
12 system. Studies of patient assessment data, this is
13 data on functional statue of beneficiaries between 1998
14 and 2001, including MedPAC's own analysis of adjusted
15 rehospitalization rates, found mixed results for
16 quality. A GAO report provides the most current
17 evidence we have showing that the overall number of
18 serious deficiencies in nursing homes declined somewhat
19 between 2000 and 2002.

20 Given this mixed picture what can we do to
21 improve the quality of care in SNFs and in nursing
22 homes? The first thing we can do is collect more

1 information with which to study quality in this sector
2 and its relationship to payments and costs. Our third
3 draft recommendation which I will turn to later,
4 addresses our need for better information in this
5 respect.

6 The next thing that we can do to improve
7 quality is to improve quality outcome measurement which
8 is still not well enough developed in this sector.
9 MedPAC, CMS, and others are working together to come up
10 with better quality outcome measures. Once we improve
11 the quality measurement then we can measure implement
12 financial rewards for SNFs that provide better quality.

13 The evidence regarding SNF's ability to access
14 capital is similarly mixed this year. CMS's annual
15 analysis of the nursing home industry suggested that
16 access to capital worsened in early 2003 due in part to
17 uncertainties surrounding Medicare and Medicaid
18 payments. However, nursing homes Medicaid funding
19 situation for this year at least appears to be
20 improving. Recent reports by both the Kaiser Commission
21 on Medicaid and the Uninsured and GAO suggests that
22 Medicaid nursing home rates remained relatively stable

1 in 2004, although both sources allude to possible
2 changes down the road if states' budget crises continue
3 to worsen.

4 Finally, some large for-profit nursing home
5 chains reported higher than expected earnings growth at
6 the end of 2003 which also helped the sector's financial
7 outlook. With respect to Medicare payments, nursing
8 home industry analysts generally view these as favorable
9 for the industry.

10 Now we turn to the Medicare margin. We
11 project the Medicare margin for freestanding SNFs to be
12 about 15.9 percent in fiscal year 2004. I want to note
13 that we just got updated data that may lower this by a
14 percentage point or so. This follows an 11 percent
15 Medicare margin for 2003, a 16.7 percent Medicare margin
16 for 2002, and a 19 percent Medicare margin for 2001.
17 This is for freestanding facilities.

18 The Medicare margin for 2004 is higher than
19 the Medicare margin for 2003 in part because SNFs
20 received the full 3.0 percent market basket update for
21 2004 plus an additional 3.26 percent payment increase
22 which represents an administrative action by CMS to

1 correct for market basket forecast errors that occurred
2 in previous years.

3 MS. DePARLE: Susanne, so what's missing from
4 this is 2003 is 11?

5 DR. SEAGRAVE: Yes. I could have put that on
6 the slide. Last year we projected the 2003 margin to be
7 11 percent, and that's still what we project this year.

8 MS. DePARLE: And 2004 is a projection as
9 well?

10 DR. SEAGRAVE: Yes.

11 MS. DePARLE: But 2002 and 2001 are actuals?

12 DR. SEAGRAVE: Yes. To give you an idea of
13 the distribution of Medicare margin across facilities,
14 we found that about 88 percent of Medicare bed days in
15 2001 were in positive margin facilities. The Medicare
16 margin for hospital-based SNFs is difficult to measure
17 correctly because of hospital cost allocation issues, as
18 you discussed in the previous discussion. We estimated
19 the Medicare margin for hospital-based SNFs in fiscal
20 year 2004 to be negative 77 percent. However, we are
21 unable to determine what this number means in the
22 context of an efficient provider.

1 As we've discussed before, freestanding SNFs
2 generally responded to the SNF prospective payment
3 system by reducing costs. We expect this trend to
4 continue into 2005. Furthermore, although nursing wages
5 may have increased for SNFs in recent years because of
6 the nursing shortage, costs may not have risen by as
7 much as wages to the extent that SNFs substituted lower
8 skilled for higher skilled labor. In addition, data by
9 the Bureau of Labor Statistics suggests that nursing
10 wage growth may be stabilizing.

11 Finally, we are aware of only one cost-
12 increasing, quality-enhancing technology in this sector,
13 vacuum assisted closure, the so-called wound vac for
14 healing wounds. We do not know the extent to which SNFs
15 are adopting this technology because of the incentives
16 in the SNF prospective payment system.

17 Finally, we believe these cost changes in 2005
18 can be accommodated within the margins SNFs already have
19 in 2004. Therefore, we recommend that the Congress
20 eliminate the update to payment rates for skilled
21 nursing facility services for fiscal year 2005. The
22 update in current law is market basket which is

1 currently estimated at 2.9 percent for fiscal year 2005,
2 and this estimate, of course, is subject to change each
3 quarter.

4 Within the budget categories that MedPAC has
5 developed, a zero update for SNFs would decrease
6 Medicare spending relative to current law by between
7 \$200 million and \$600 million in one year and between \$1
8 billion and \$5 billion over five years. Because we
9 project the Medicare SNF margin to be 15.9 percent for
10 2004, we do not anticipate major implications for
11 beneficiaries or for providers of this recommendation.

12 However, we would like for this overall pool
13 of money to be better distributed across the different
14 types of patients cared for in SNFs. Thus, we reiterate
15 our recommendation from last year which is intended to
16 improve access to SNF care for those types of
17 beneficiaries I mentioned earlier that may be having
18 difficulty accessing SNFS, and distribute money more
19 accurately among providers.

20 We recommend that the Secretary develop a new
21 classification system for care in SNFs, and because
22 there needs to be a more immediate fix to the

1 distribution of money in the SNF payment system, the
2 Congress should authorize the Secretary to remove some
3 or all of the 6.7 percent payment add-on to
4 rehabilitation RUG groups and reallocate money to the
5 non-rehabilitation RUG groups to achieve a better
6 balance of resources in the system.

7 As we added this time again, if necessary
8 action on this does not occur by October 1st, 2004, the
9 Congress should provide an update to payment rates for
10 hospital-based SNFs of market basket minus 0.9 percent
11 adjustment for productivity.

12 The portion of this recommendation that deals
13 with hospital-based SNFs would decrease spending
14 relative to current law by less than \$50 million in one
15 year and by less than \$250 million over five years. The
16 other part of the recommendation we assume would be
17 spending neutral. This recommendation as intended would
18 potentially provide better access to SNF care for
19 certain types of beneficiaries and more accurately
20 distribute Medicare payments among providers.

21 Finally, so that we and others may better
22 study the relationship between nursing costs, total

1 costs and quality of care in this sector we recommend
2 that the Secretary direct SNFs to report nursing costs
3 separately from routine costs on their Medicare costs
4 reports. Facilities in some states are already doing
5 this. This recommendation has no spending impact, would
6 have no effect on beneficiaries and would likely mean a
7 modest additional cost for providers.

8 This concludes my presentation and I welcome
9 any questions you may have.

10 MR. DURENBERGER: Thank you very much. My
11 question is going to relate to quality. The basic
12 question is, we've been talking about paying for
13 performance and things like that, and my concerns --
14 I've skipped my concerns about cross-subsidizing
15 Medicaid and all that sort of thing so this really
16 relates to whether or not changing payment or increasing
17 payment actually have or can have an impact on integral
18 quality. In other words, if you were going to pay for
19 performance in the sub-acute system, what would you pay
20 for and how would you construct the system? The only
21 distinction I could gather from some of this material,
22 and I may have misinterpreted what you presented was,

1 pull out the routine cost from nursing costs and some
2 things like that.

3 But I know the National Quality Forum has been
4 working on measures. I know that Tom Scully thinks he's
5 got measures. I know that he's been advertising that
6 you can call a number and rate this nursing home versus
7 -- but I still don't get what's quality when I -- and I
8 haven't tried to call the number, but I'm still not sure
9 of what the definition of quality is. But more
10 importantly, what role payment or payment policy has as
11 it relates to the quality. Can you help me understand
12 that a little better?

13 DR. SEAGRAVE: To start off maybe with your
14 second point, I think we are still struggling with what
15 quality means in this sector. I think that's why we
16 still have to develop better quality measurement in
17 order to be able to reward providers that demonstrate
18 better quality.

19 MR. DURENBERGER: Does that mean better
20 measurements than the ones that allegedly the National
21 Quality Forum produced, or am I misinterpreting what
22 they did last year?

1 DR. SEAGRAVE: I think in terms of whether the
2 government can use the measures that the National
3 Quality Forum developed, whether Medicare's purpose for
4 those measurements would be the same as the National
5 Quality Forum's purpose, those kinds of things I think
6 still need to be worked out. So I think we're still a
7 little ways away maybe from having the type of quality
8 measurement that we might need to be able to reward
9 quality.

10 Then getting to your second question about the
11 relationship between Medicare payment and quality, I
12 think there have been many -- I'm glad you brought that
13 up. I think there have been many studies recently about
14 the relationship, not just between Medicare payment but
15 between financial performance in nursing homes
16 specifically and quality. I think that those have shown
17 that the relationship is not very clear, and in fact a
18 recent study showed that for-profit nursing homes in
19 California that have greater than 14 percent margins
20 actually display lower quality in terms of the number of
21 deficiencies that they show. So I think that there's
22 not a clear-cut relationship between payment and quality

1 and that's why I think breaking out the nursing costs
2 from the total costs and looking at that, and looking at
3 payments and costs and quality relationship, I think
4 more work needs to be done.

5 MR. DURENBERGER: I'd just summarize by
6 saying, just as a layperson who uses the system for
7 family members, I'm very confused when I hear the word
8 quality being used by the administrator of CMS and a lot
9 of people, and I'm not sure that we really know what
10 we're talking about. Yet when I sit here to try to make
11 a judgment on payment adequacy I'm more inclined to
12 think about quality than I am about access because I
13 think it seems like we've solved a lot of the access
14 problems, or at least some of the access problems, some
15 substantial part of the access problems, but I'm not
16 sure about the quality part. So I'm left unsure about
17 how to deal with that and I would interpret your answer
18 as saying, at the present stage we don't have much to be
19 helpful to you, if that's your questions.

20 MR. HACKBARTH: In this context where we have
21 high average margins, adding more money to the system is
22 not a very powerful tool for trying to improve quality I

1 think is one of Susanne's basic points. They've got
2 enough money now. The incentives are to reduce costs.
3 If you really want to improve quality you would be
4 better off identifying what you regard as improved
5 quality and paying specifically for that.

6 MR. DURENBERGER: That's precisely why I asked
7 the question.

8 MR. DeBUSK: Glenn, are we adding or are we
9 taking away? You said by adding more money.

10 MR. HACKBARTH: This recommendation is for no
11 update.

12 MR. DeBUSK: No update. But the update is
13 designed to keep up with the cost of services provided
14 from year to year, right?

15 MR. HACKBARTH: And they have average margins
16 of 15 or 16 percent currently.

17 DR. MILLER: Just a couple other things on the
18 quality point. I'm going to need some help here so if
19 Karen and Susanne can both follow me here. There are
20 people mining the MDS data to look for quality measures
21 and that is part of CMS's effort; is that correct?

22 MS. MILGATE: Yes.

1 DR. MILLER: And then there's the notion of
2 nursing home quality measures which I think some other
3 groups are mining those measures. I'm just looking for
4 a nod or a clarification.

5 MS. MILGATE: CMS is looking at nursing homes
6 too.

7 DR. MILLER: Just to be clear, that's distinct
8 from SNF. We ourselves are looking at some readmission
9 indicators; is that correct? And we're would going to
10 be doing some analysis on the relationship between cost
11 and quality down the road.

12 DR. SEAGRAVE: That's correct.

13 MS. RAPHAEL: I happen to believe that one of
14 the most important areas of quality in nursing homes
15 happens to be staffing, and that while you have a 100
16 percent turnover rate in CNAs and if you don't have the
17 nursing staff it's just going to be very hard. It's one
18 of the few places where I feel inputs are probably as
19 important as outcomes. So I'm wondering if we're
20 looking at that in the work underway.

21 DR. SEAGRAVE: Certainly. The CMS web site,
22 they report staffing levels by nursing facility. We're

1 looking at costs and quality and staffing levels,
2 because I think there have been a number of studies on
3 the relationship between staffing levels and quality in
4 nursing homes. I think we're continuing to look at that
5 and try to find out what's going on there.

6 MS. RAPHAEL: Do they report retention rates?

7 DR. SEAGRAVE: No.

8 MS. DePARLE: As I recall that's really
9 difficult to get.

10 DR. MILLER: Susanne, that's one of your
11 motivations for the third recommendation, is to try to
12 break out the nursing costs as separate. Not perfect,
13 but to begin to drive in on how much of their resources
14 are going to nursing and whether there's a relationship
15 between that and equality.

16 DR. ROWE: Carol, when you say 100 percent
17 turnover, if there are 20 nurses --

18 MS. RAPHAEL: No, CNAs.

19 DR. ROWE: All right, let's take them. Do you
20 mean that all 20 of them change, or that maybe 10 of
21 them stay the same for years and years and years and the
22 other 10 slots turn over a couple times a year? So

1 you've had 20 turnovers; i.e., 100 percent turnover, but
2 in fact you still have a core of people who are there
3 for -- what do you mean when you say 100 percent?

4 MS. RAPHAEL: I don't know for sure because
5 I'm not sure there's consistency in how --

6 DR. REISCHAUER: It's almost always the
7 latter.

8 DR. ROWE: That's what I think. So the
9 turnover rates exaggerate the impact a little bit maybe.

10 MS. RAPHAEL: Although I think they're very
11 high in the first six months from what I remember.

12 DR. ROWE: When people learn what the job is.

13 MR. SMITH: Just quickly I want to underscore
14 Carol's concern on the nursing side of this. It's not
15 just a question of nursing costs or share of costs
16 allocated to nursing but something about staffing,
17 something about training, something about turnover, and
18 turnover up and down the hierarchy matters a lot. I
19 think, Bob, you're right that it tends to be some
20 stable, some turnover a lot pattern, but that's not
21 within the same job category. At entry level job
22 categories the absolute turnover is higher and

1 supervisors tend to be more stable.

2 Just a quick quibble on recommendation two.
3 It seems to me we ought to make sure that the
4 recommendation says that we're talking about the same
5 money in the second bullet that we're talking about in
6 the first and we don't. We could be talking about two
7 different chunks of money. So it's only the money, or
8 reallocate some of the money or some such change.

9 DR. REISCHAUER: My question dealt with the
10 same issue. Susanne, I was wondering if we had any kind
11 of feel for if the first part of the recommendation
12 occurred what it would be equivalent to as an update for
13 hospital-based SNFs? I didn't know if these two things
14 are different ways of doing very similar things or one
15 is, let's go for a vacation and if we don't go for a
16 vacation, let's buy a car. Are hospital-based SNFs
17 heavily into non-rehab RUG services or not? Because if
18 they aren't it's sort of like, does this really connect?

19

20 DR. SEAGRAVE: I think it's hard to determine
21 -- across the board it's hard to say if they're more
22 into rehab, more into non-rehab, those kinds of things.

1 I think that the recommendation is designed to more
2 accurately distribute payments among different types of
3 providers, and to the extent that a particular hospital-
4 based SNF treats a higher proportion of non-
5 rehabilitation patients then it is designed to funnel
6 more money to them. But I think it's still an open
7 question whether hospital-based SNFs are treating a
8 higher proportion of non-rehabilitation patients.

9 DR. REISCHAUER: So it's conceivable that if
10 the first part of the recommendation happened it
11 wouldn't do anything for hospital-based SNFs.

12 DR. NEWHOUSE: But going beyond that, to raise
13 whether we want the second part of the recommendation at
14 all.

15 DR. REISCHAUER: It might hurt them. Without
16 knowing that it strikes me that either they should be
17 two separate recommendations or else we should be
18 careful about what we're suggesting.

19 DR. MILLER: I thought, and again I could have
20 missed something in the process here. I thought that at
21 one point we had some indication when we were looking at
22 case mix differences between the two that there was some

1 thought that they were more heavily mortgaged in the
2 non-rehab. Is that not the case?

3 DR. SEAGRAVE: I think we think they are
4 treating a higher case mix of patients. I think that
5 there's some indication, although it is based on older
6 data, that they are treating a higher percentage of non-
7 rehabilitation patient. But getting the more current
8 data and figuring out whether that's still the case or
9 not, I'm basically not willing to go out on a limb right
10 here in front of everybody and say that they
11 definitively are at this point.

12 DR. MILLER: That's appreciated. But when we
13 drafted this up last year we had some thought in our
14 mind that it would be redistribute it. But you're
15 saying, to be completely careful about it you would want
16 to see the most current.

17 MR. MULLER: Would you remind me again what
18 the distribution is between the profits and not-for-
19 profits in terms of their rehab share? I seem to
20 remember from last year we had some numbers on that.
21 Weren't the rehab services higher in the for-profits
22 than the not-for-profits?

1 DR. SEAGRAVE: I honestly don't remember that
2 data from last year. That would be my guess.

3 MR. MULLER: I seem to remember we had it
4 before so that should be retrievable as opposed to a new
5 --

6 DR. REISCHAUER: If that isn't the case we
7 have to rethink capitalism.

8 MS. BURKE: Two questions. One, on the issue
9 of nursing and the third recommendation, which I think
10 is terrific, one of the questions that ought to occur
11 once we actually separate these things out is some
12 understanding of what we mean and the differences in
13 what nursing is. Nursing costs as stated will include a
14 broad range of what are defined as nurses. The
15 question, and in fact there is research on this topic
16 and some data available on the impact of the presence of
17 professional nurses. Is that the word we use now?
18 Registered nurses, whatever the word is that we
19 currently use, that there is in fact a direct impact of
20 the presence of registered nurses as compared to a
21 broader array of nurses.

22 So one of the things I would hope we'd be able

1 to do as we develop this information, or if we can
2 understand if there is in fact that difference, is it
3 just nurses, nursing cost, money spent on X more LPNs or
4 X more aides, or is it in fact -- does it differentiate
5 if in fact the money is spent on fewer but they are
6 registered nurses as compared to nurses aides? Just for
7 purposes of understanding what that impact intent is.

8 The second question is, at the risk of getting
9 back into the conversation about margins, nonetheless on
10 page 14 we again avoid the obvious question and the
11 specifics by stating that the aggregate Medicare margin
12 for hospital-based SNFs remain low. What I think I
13 heard you say was that it's negative 77 percent. That
14 is certainly a definition of low. But again, they will
15 ask the obvious question and the question is, do we
16 address it directly or do we not? But I think just
17 simply referencing low and a statement of margins that
18 are in the 15 and 16 percent, whatever it is versus a
19 negative 77, one might think we might want to explain
20 once again that there is a number there that is not a
21 number we're solid with. But it will just lead to the
22 inevitable question, what does low mean? You've stated

1 it affirmatively for freestandings. We know what it is.

2 What does that mean?

3 So again, I don't want to get back into that
4 debate but I think we need to be -- the question is
5 going to come so we may as well be prepared to deal with
6 it one way or another.

7 DR. NEWHOUSE: I was going to let Bob's other
8 shoe drop. Should we take out the last part of two, not
9 only because we seem to lack data but also because even
10 if we had data showing differences, as Bob said on the
11 home health, it's not clear we would want to pay for it.

12

13 DR. REISCHAUER: My question is whether we
14 shouldn't break up recommendation two. The first part
15 of it seems to be, let's get the distribution of
16 payments better. We don't know if that's going to help
17 hospitals or isn't going to help hospitals. But if we
18 think there's a problem in hospitals then we should have
19 a recommendation saying hospitals should have some kind
20 of an update. If we're concerned about the overall
21 level what we should say is, we should take the 6.7
22 percent payment add-on, take a chunk of that to

1 distribute across payment categories to make them
2 better, and take another chunk of it and use it for a
3 hospital-based SNF update.

4 DR. NEWHOUSE: Why do you want to do the
5 latter?

6 DR. REISCHAUER: Why do we want to do the
7 latter in this recommendation now?

8 DR. NEWHOUSE: I don't know.

9 DR. REISCHAUER: Presumably because we think -
10 -

11 MR. SMITH: This recommendation at the moment,
12 Glenn, I had wanted to go to the same place -- suggests
13 that we know something about the distribution of non-
14 rehabilitation patients, that they are skewed toward --
15 otherwise this recommendation doesn't make any sense.
16 We're going to shift the money from rehab groups to non-
17 rehab groups, but if we can't, we want to give money to
18 hospital-based SNFs. We have to assume, Mark, that
19 there is a distributional of relationship as your
20 remembered, but we don't recite it anywhere here and
21 there's been -- this discussion makes me wonder whether
22 or not the only recommendation that we really have any

1 grounds to make is the last part, I think which is where
2 Bob was going, the last part of what is now two. To
3 remove the 6.7 doesn't make any sense.

4 DR. MILLER: If I could just say one thing on
5 the 6.7, regardless of what we thought was going on in
6 hospital-based, we believe that the system as it's
7 currently constructed in terms of the relative weights
8 the money should be redistributed, and that the money
9 will better track the patient. So regardless of where
10 they ended up, hospital-based or non-hospital-based, we
11 think that should happen, on the basis of analysis that
12 we've done of the payment system.

13 Now rightly or wrongly last year -- and I'll
14 take responsibility for this -- in looking at case mix
15 we thought there may be something to the story that they
16 may be taking more of these patients, and made the point
17 that this redistribution may help those hospital-based
18 SNFs. I think Susanne is beginning to say, I need to be
19 sure that that's still the case so we may be walking
20 away from that.

21 I think this recommendation, the
22 redistribution stands on its own merits. We've been

1 over this ground. I think the question becomes what to
2 do about the second one.

3 MR. SMITH: But the second one is now offered
4 as an alternative to the first one, suggesting that
5 we're trying to accomplish the same thing. We clearly
6 shouldn't do that.

7 DR. MILLER: The linkage should not be there.
8 I agree with that.

9 MR. SMITH: So if there's a justification for
10 the second half of recommendation two as drafted it is
11 that we think that hospital-based SNFs are in some
12 trouble.

13 MS. RAPHAEL: But the rehab data, as I
14 remember, showed they had shorter length of stay and
15 higher case mix and higher nursing staff. That's what I
16 remember. I don't remember information about rehab and
17 the degree to which they provided rehab.

18 MR. SMITH: No, but I think that's exact -- or
19 at least we're uncertain about that, Carol. So that
20 suggests that even if we accomplish the desirable
21 redistribution among RUG groups that we have to then ask
22 ourselves, do we have an institutional issue here which

1 suggests that for whatever reasons hospital-based SNFs
2 need additional resources? I don't know that we've made
3 that case here.

4 DR. NEWHOUSE: I want to go back into history.
5 In the early 1990s entry conditions for hospital SNFs
6 were especially favorable. You could get your costs
7 back, and they expanded very rapidly. What we've seen
8 post-BBA is a considerable contraction in the for-profit
9 hospital SNFs, which just suggests to me that for-profit
10 firms were pursuing profit in the early '90s. BBA took
11 it away and they exited. It's not clear to me that
12 there's anything bad at the end of the day from all of
13 this.

14 I think there's a downside to this
15 recommendation even beyond trying to fix up the SNF side
16 in a way that may or may not be very good, which is that
17 we're going to reintroduce differential payment rates
18 according to site of care, which is, I think, a
19 principle we don't want to do.

20 MR. HACKBARTH: So, Joe, your proposal would
21 be to drop this --

22 DR. NEWHOUSE: To strike this last clause and

1 go with the first part.

2 DR. REISCHAUER: To be fair, what we should do
3 is split them and vote on it, rather than --

4 DR. ROWE: With respect to your historical, I
5 think payment had something to do with it, but one of
6 the other things was that length of stay was falling in
7 hospitals. Occupancy rates were way down. There were
8 lots of empty wards. There were resources in search of
9 needs. There were people trying to figure out how to
10 use those facilities, and that fed a lot of the
11 development of hospital-based SNFs.

12 DR. NEWHOUSE: The one reason length of stay
13 was falling was one could unbundle the DRG payment, put
14 the marginal day over in the SNF.

15 MS. BURKE: I'm perfectly comfortable
16 splitting these. I think that makes perfect sense. But
17 before outright rejection of this last question, and not
18 necessarily this proposal but the issue of hospital-
19 based, I think some thought -- I'm almost hesitate to
20 suggest we even vote on this. I wonder if we shouldn't
21 set it aside rather than defeat it, and get a better
22 understanding of what the issue is that we're trying to

1 deal with. There are geographic issues. There is a
2 predominance of these folks in rural areas. What
3 implications that has, I don't know.

4 Joe's point about the rapid increase in the
5 number of home health agencies in the early '90s is
6 absolutely right. Whether or not what remains are
7 predominantly for-profit, whether it's just all the for-
8 profits that have left that would suggest it's just a
9 question of whether there's profit or not, I don't know
10 the answer to that question without looking at -- but
11 Joe may have a very good point.

12 But I think there's an issue here, a minus 77
13 percent margin would suggest there is an issue. I guess
14 my preference would be to understand that more clearly
15 before we reject out of hand that there's initiative
16 there that needs to be dealt with.

17 MR. HACKBARTH: I agree with that, Sheila.
18 Rather than defeat it on an uncertain factual basis I
19 would just say, let's take it up at a later date, get
20 some more facts and set it aside for now. So the
21 proposal on the table would be to vote on the
22 reallocation proposal only.

1 MS. BURKE: Could we accompany that -- what I
2 would also not want to do is leave it unstated that
3 there is an issue at least the Commission is interested
4 in pursuing, and that while we have not adjusted in
5 those go-round that it is our intention to examine more
6 carefully. So I think the document ought to reflect,
7 the issue has arisen. We chose not to address it here
8 in the absence of information, but in fact we
9 specifically intend to do so.

10 DR. SEAGRAVE: Can I just add to this
11 conversation just quickly? We have two major research
12 projects going on right now with outside contractors,
13 both of which are devoted to studying hospital-based
14 SNFs and what happens in areas where hospital-based SNFs
15 close, and what the products that hospital-based SNFs
16 are delivering is. So we have that, plus we are also
17 doing a really serious look at hospital-based SNF costs.
18 So all three of those.

19 DR. WOLTER: This would be anecdotal, but in
20 my own experience with hospital-based SNFs in my part of
21 the world in fact the physicians putting patients there
22 are choosing patients they wouldn't send to freestanding

1 SNFs because in their assessment they're more fragile,
2 need more resource. Also I would say, and this is just
3 my own institution so it's an N of one, we have
4 different standards around nursing ratios and mix of
5 nurses and those sorts of things. So I think that at
6 least in some cases there is probably something
7 different going on.

8 Then back to this overall Medicare margin
9 discussion, if we're concerned about hospitals' overall
10 Medicare margins, how do we decide to fund a full market
11 basket in inpatient and outpatient versus SNF versus
12 whatever? That's why I'm a little bit concerned about
13 where we're headed with this, because it may be that in
14 fact the overall Medicare margin in hospitals is in some
15 decline in part related to their SNF margins as opposed
16 to inpatient or outpatient. So I worry a little bit
17 about how we make these decisions as we start lumping
18 everything together.

19 MR. HACKBARTH: What we can say is that as a
20 proportion of the overall book of business, the
21 hospital-based SNF is a very small fraction of the
22 total. I don't know those numbers off the top of my

1 head but it's just a couple percent.

2 DR. SEAGRAVE: 2 percent.

3 MR. HACKBARTH: About 2 percent. So it can't
4 be a principal driver of what's happening to the overall
5 margin. It's just not big enough.

6 MS. RAPHAEL: I'm sure all of us have received
7 a lot of material and I just read some of the material I
8 received from so of the people in the nursing home
9 sector and they made the point, which I just think we
10 should go back and check and I will give to you,
11 Susanne, that they are already reporting nursing costs
12 apart from routine costs in line 16 of some form, and
13 all the rest of that. I'll pass this on because we just
14 ought to confirm that it's not --

15 DR. SEAGRAVE: I'll tell you that I've spoken
16 with some experts on the SNF cost report and I and the
17 experts I spoke with do not believe that's what's
18 currently being reported or what is going to be reported
19 on the SNF cost reports, is getting at exactly what we
20 want to understand. So I'm actually going to discuss
21 that with --

22 MS. RAPHAEL: We should put it in the text

1 probably too.

2 MR. DeBUSK: Nick, in the allocation of
3 overhead at your institution is that not done on a
4 square footage basis? So a nursing home owned by your
5 operation, it could be sizable then, right, from a
6 dollar standpoint?

7 DR. WOLTER: In our case the SNF is located
8 on-site so it's the size of a nursing unit in essence.

9 MR. DeBUSK: You say that's 2 percent?

10 MR. HACKBARTH: We're talking about overall.
11 Not all hospitals have hospital-based SNFs, but --

12 MR. DeBUSK: Yours could be considerably
13 higher then, right?

14 DR. WOLTER: This whole accounting issue, I
15 believe needs to have a little light shed on it. I
16 would just say this, I don't think that we're doing any
17 arbitrary allocation of costs to SNF or anything outside
18 of inpatient. It may well be, however, that our overall
19 overhead for the institution, the indirect costs, are
20 higher than it might be for a freestanding, smaller
21 operation. Therefore in the allocation methodology more
22 costs end up getting allocated. I assume that's at

1 least part of what goes on. But I just can't come up
2 with any information anymore suggesting that hospitals
3 are arbitrarily allocating costs from inpatient to
4 outpatient. I just don't see that in my life.

5 DR. NEWHOUSE: When I said arbitrary, I meant
6 just a convention that could be a different convention
7 that would lead to a different allocation. So square
8 footage, in my view, is an arbitrary way to allocate
9 cost. It can be consistent over time, and that's the
10 rule. You could allocate it in some other fashion that
11 would lead to a different allocation. I would go on and
12 add, if the Commission pursues this, I think it ought to
13 try to get some measure of direct costs for these
14 various lines of business. That is, the costs before
15 any allocations are made. That I think would be -- that
16 has some meaning as a number to look at.

17 Now the indirects have to be covered in some
18 fashion, which gets you to the most-of-Medicare margin,
19 but that's not what we have now.

20 MS. BURKE: Can I ask a question? Remind me
21 what we do with swing beds currently.

22 DR. SEAGRAVE: The swing beds in critical

1 access hospitals are not covered under the PPS, and
2 those are not included. I believe other sorts of swing
3 beds were first included in the PPS, I believe starting
4 in 2002, so our data for the most part still has not
5 included them. I'm not sure what we're going to do
6 about them next year. I'm not sure if they're going to
7 be somehow -- anyway, the short story is I don't think
8 they're included in our analysis at the moment.

9 MS. BURKE: And the prevalence today swing
10 beds? How many hospitals actually --

11 DR. SEAGRAVE: I could get back to you on
12 that. I don't know that --

13 MS. BURKE: I don't know whether their
14 experience will lend us any knowledge about the nature
15 of the hospital-based nursing home patient. I mean,
16 understanding what they look like, how they're dealt
17 with. Arguably, they would be comparable, presumably,
18 to any other hospital-based unit, skilled unit. It's
19 just the hospital's choice of how one structures. But I
20 don't know whether any understanding -- just as you're
21 looking at this issue and giving the studies that are
22 going on, I don't know whether that would inform us at

1 all, but it would be interesting to know what the nature
2 of those folks are and whether there's any
3 comparability.

4 DR. SEAGRAVE: I will tell you that what I've
5 heard a lot of people say, particularly actually in
6 rural areas, is that it's easier for them to, perhaps to
7 close their hospital-based SNF and just have swing beds.
8 that makes it easier administratively.

9 MR. HACKBARTH: Last comment.

10 DR. REISCHAUER: Just a question. What
11 happens in critical access care hospitals? The SNF is a
12 separate unit, right? But we're talking about
13 possibility in the past of shifting administrative costs
14 onto the cost-based reimbursement and now we've gone the
15 other way, so you could see a lot of the administrative
16 costs --

17 MR. ASHBY: In the past they have not been
18 allowed to have SNFs so it really hasn't been an issue
19 for critical access hospitals. They do have swing beds,
20 of course, so it's the same issue.

21 MR. HACKBARTH: Let's go back and vote on the
22 recommendations. All opposed to recommendation one?

1 All in favor? Abstentions?

2 All opposed to recommendation --

3 DR. NEWHOUSE: Just this much of it?

4 MR. HACKBARTH: Just this much. We're
5 dropping the part about the market basket increase for
6 hospital-based SNFs as an alternative. So it's just
7 this piece.

8 All opposed to this? All in favor? Abstain?

9 I think that's it then, right?

10 DR. NEWHOUSE: Number three.

11 MR. HACKBARTH: That's right. All opposed to
12 number three? All in favor? Abstentions?

13 Okay, thank you.

14 Last up is inpatient and outpatient hospital
15 services.

16 MR. ASHBY: Good afternoon. This is the
17 hospital session. I'm going to begin this session by
18 presenting overall Medicare margin data which support
19 our assessment of payment adequacy for the hospital as a
20 whole. Extending beyond the data that we presented in
21 December, this time we'll be including information on
22 margins by hospital group and data on the distribution

1 of margins. Then Julian will address payment adequacy
2 as well as our draft update recommendation for inpatient
3 services, David will briefly update our information on
4 access to capital, and Chantal will present outpatient
5 margin information and our outpatient update
6 recommendation.

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

21 In addition to our mistake we also discovered
22 a problem in CMS's cost report file. We corrected for

1 the bad data through imputing and that lowered our
2 estimate of the outpatient margin that we presented in
3 December, and Chantal will, a little later, give you the
4 details on that.

5 Now onto the values. We see in this chart,
6 obviously, that we have a small reduction in margin in
7 '01, a larger reduction in '02 and essentially no change
8 to '04. Unusually large cost increases were
9 instrumental in both the '01 and the '02 decreases in
10 margin, but in '01 the cost increase was offset somewhat
11 by an increase in DSH payments that was mandated by BIPA
12 and a large increase in outpatient payments that
13 followed the implementation of the outpatient PPS.

14 After '02, the almost constant margin
15 represents the net effects of a substantial increase in
16 payments from a number of DIMA provisions and CMS's
17 tightening of inpatient outlier payments. Excessive
18 outlier payments pushed total inpatient payments nearly
19 2 percent higher than was intended in 2002. Our
20 simulation for '04 assumes that the system reforms that
21 CMS implemented will return aggregate outlier payments
22 to the targeted level. It's quite possible that within

1 that time frame outliers will not drop all the way back
2 to the target level, in which case the margin estimate
3 that we have shown would, all else equal, be too low.

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

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

21 The next chart summarizes some of the key
22 factors causing the unusually large rate of growth in

1 per-unit costs. In this analysis we're looking at all
2 costs. That is for all services across all payers. We
3 found a major impact from increased labor costs,
4 including both increases in wages and benefits and
5 increases in use of labor, and that the increases were
6 concentrated particularly in the area of nursing
7 personnel. But as we talked about in December there is
8 already evidence that the rate of growth in labor cost
9 is abating. BLS data show that hospital wage and
10 benefit increases peaked at about 5.5 percent in 2002
11 and that increase was down to about 4 percent by the
12 third quarter of 2003. That's actual data through the
13 third quarter of 2003.

14 Similarly, hospital employment increases
15 peaked in 2002 at about 2.8 percent and they were down
16 to about 2 percent by the third quarter of 2003. Then
17 we had smaller impacts from drugs and chargeable
18 supplies, and that would include devices, malpractice
19 costs and capital expenses. On the drug issue, the rate
20 of interest in overall drug spending has moderated
21 somewhat in '03 but we're not really sure how that
22 played out for drugs provided in the course of hospital

1 care. Malpractice costs tend to be very cyclical, so
2 the unusually high rate of growth that we saw in 2002 is
3 bound to moderate at some point in time.

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

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

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

1 2004 figure reflects the provisions of DIMA as if they
2 had been in place in 2004 and also changes in policy
3 occurring between '02 and '04. I need to begin here by
4 noting that we couldn't model two of the provisions of
5 DIMA at the group level so all of the group-level
6 margins in this table are understated by an average of
7 about 0.4 percent. The two provisions in question here
8 are a one-time opportunity for hospitals to appeal their
9 wage indexes, which CBO has estimated will bring \$300
10 million into the payment system, and also liberalize
11 payment policy for critical access hospitals.

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

21 Now as for the changes by group, the drop in
22 margins for urban hospitals primarily reflects the

1 impact of tightened outlier payments together with a
2 modest increase in payment from DIMA. Rural hospitals,
3 on the other hand, benefit tremendously from DIMA, as
4 was intended, but they receive little outlier payments
5 so they were not affected much by the tightening of
6 outlier policy.

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

19

20 On the distribution of margins, in 2004 and
21 reflecting the impact of DIMA provisions, we estimate
22 that about 50 percent of hospitals will have a negative

1 margin. And using the weighted measure, that is the
2 percent of payments that go to negative margin
3 hospitals, the figure would be about 46 percent.

4 MS. BURKE: Could you repeat that?

5 MR. ASHBY: This is 2004 reflecting the impact
6 of the DIMA provisions. At that point we estimate that
7 50 percent of the hospitals would have a negative
8 margin, but if we did it on a weighted basis, 46
9 percent.

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

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

16 MS. BURKE: And overall it has an estimate of
17 1.8.

18 MR. ASHBY: Right.

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

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

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

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

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

1 minus 3.1.

2 MR. MULLER: We discussed this last month but
3 what inflators were you for using for 2002 to 2004? You
4 made the point in your presentation earlier that -- you
5 had the 6.6 and the 5 percent, the 6.6 for inpatient and
6 5.5 for overall. But what are you using to go from 2002
7 to 2004 to get to your '04 estimate?

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

10 MR. MULLER: So roughly around three.

11 MR. ASHBY: Roughly in the neighborhood of
12 three.

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

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

18 MR. MULLER: As I think we discussed it -- I
19 don't want to go through the whole thing again as we did
20 last month, but at last for probably '03 we can all see
21 next year where we come out on these things but my guess
22 it's going to be closer to five than three, so that

1 could throw even more of the hospitals into negativity
2 if the 1.8 --

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

17 DR. WAKEFIELD: Jack, when I'm looking at the
18 estimated '04 rural, a little bit to Sheila's point
19 earlier, and the non-teaching category of minus 1.6 and
20 trying to get as clear a fix on what that category of
21 non-teaching looks like since it seems to be doing the
22 poorest here of all the different categories, Sheila was

1 asking about might there be difference by rural-urban,
2 for example, and you said, yes, the urban non-teaching
3 probably are minus 3.1 and the rural non-teaching is
4 going to be a lot closer to 2.3. That 2.3 includes CAHs
5 in it; is that correct?

6 MR. ASHBY: No, it does not.

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

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

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

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

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

18 MR. ASHBY: Exactly.

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

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

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

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

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

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

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

21 As you think about these questions though,
22 it's important to take into account the evidence that we

1 presented back in December on the other indicators that
2 we use in the payment adequacy framework, and those are
3 shown on this slide here. To briefly recap the
4 findings, first, we found no evidence of any
5 deterioration in beneficiaries' access to care based on
6 providers participation in the Medicare program, on
7 changes in their capacity to furnish services, or on
8 beneficiaries' use rates.

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

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

18 Available information also suggests that
19 access to capital remains adequate although the cost of
20 capital varies among hospitals. Now since the December
21 meeting some additional reports on hospitals'
22 creditworthiness and access to capital have come out and

1 those reports have led some people to suggest that
2 access to capital has been deteriorating or is about to.
3 We've been looking into that and David is now going to
4 summarize our findings.

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

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

22 Now the other question is, is capital spending

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

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

20 Conversely, an old hospital with low
21 depreciation expenses might spend a lot on fixing the
22 roof and that sort of thing and have a high index but

1 not be in particularly good shape. So the individual
2 values for this index that they introduced may not be
3 particularly informative.

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

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

16 That brings us to the second stage of the
17 update framework. As shown on this slide, this update
18 will apply to Medicare's inpatient operating payment
19 rates. Given that aggregate payments are currently
20 adequate, the issue is how much efficient hospitals'
21 inpatient operating costs should increase in 2005, not
22 counting any changes in volume or case mix which the

1 payment system adjusts for automatically? Under current
2 law the update is set equal to the projected increase in
3 the market basket index. There's also a provision that
4 provides for a 0.4 percent reduction for hospitals that
5 fail to furnish quality data.

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

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

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

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

1 recommendation.

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

6 DR. ROWE: Can I ask a general question about
7 -- whenever we go through this we always hear from the
8 industry, and I'm sure it's accurate, yes, the average
9 hospital did so-and-so but their Avogadro's number of
10 hospital that did very badly or are on the brink of
11 suffocation, which may be true. I believe it. You give
12 us numbers which are mean numbers and you talk about
13 adequacy in the aggregate, is the term you use, in terms
14 of access to capital, in terms of X or Y or Z. I think
15 this is just worth a minute or to of conversation
16 because I think everybody's right. These data are
17 right, but the concerns about the vulnerable
18 institutions are valid also, and not all hospitals are
19 the same.

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

1 quickly --

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

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

1 addressing those issues specifically as opposed to just
2 increasing the update for everybody.

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

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

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

21 MR. HACKBARTH: I think that as some of the
22 questions have already have indicated it would be

1 worthwhile to look at the non-teaching category some
2 more and try to understand what is going on there. I
3 want to be clear though that this is not a results-
4 oriented analysis. I don't think we want to fall into
5 the trap of saying, this category has a negative margin,
6 therefore we ought to just increase payments to them.
7 What we did in the case of rural hospitals was
8 analytically look at how the system adjusted for various
9 factors and conclude that they were inappropriately,
10 unfairly being hurt. It wasn't just that they were
11 losing money. The system wasn't sufficiently refined to
12 deal with their unique characteristics.

13 So we don't want to just create a new non-
14 teaching category that has a special update factor, a
15 special payment adjustment just because they lose money.
16 That would be a mistake in my view.

17 DR. ROWE: One final question on this, and I
18 find this helpful and I hope others do, is when we look
19 at an individual subset or subsets of a population of
20 doctors or hospitals or nursing homes or SNFs or
21 whatever and we see that they're disadvantaged, not that
22 just their results are underwater but that they're

1 disadvantaged because of whatever, then do we have a
2 policy with respect to the budget neutrality or not of
3 recommendations we make with respect to fixes for that
4 set of institutions?

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

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

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

21 DR. REISCHAUER: But there is this
22 distribution issue which is, what if the 10 largest

1 hospitals in the United States had, or the 50 largest
2 had margins of 3,000 percent and everybody else was
3 negative, would you be happy? No.

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

18 In each of the prior discussions the
19 presumption is that productivity, that there is an
20 adjustment for productivity that is relatively uniform
21 across the sector. We come to hospitals and in fact, as
22 I understand the recommendation, we make no adjustment

1 for productivity. That is one piece of this broader
2 concern of mine that we are going to have to explain to
3 folks who will look at this and say, why in this case
4 did they decide that because there is uncertainty -- I
5 mean, I think a lot of the conversation here has been
6 quite helpful, but there is uncertainty in everything.
7 There's nothing certain about anything that we've talked
8 about all morning.

9 So every other sector is going to be equally
10 as confused about a lot of the changes that are coming
11 into play and a lot of the other dynamics. So I think
12 it's going to be incumbent upon us to help people
13 understand why this in fact is different, why the
14 recommendation here doesn't have a productivity
15 adjustment.

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

20 MS. BURKE: But what concerns me is not just
21 about the margin. That would be the natural
22 presumption, here's a margin of X so you can take this.

1 There's no magic margin number as far as I can tell, and
2 I think looking in from the outside, we have the benefit
3 of enormous conversation and tremendous input by the
4 staff, but when you look at it free of that I think it
5 is incumbent upon us to give people some sense of it's
6 not just the margin. It is a whole series of
7 considerations that have to be taken into play when we
8 look at these things. But this one will look odd in
9 some respects as compared to the others, particularly
10 around productivity in the broader question.

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

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

22 First of all, I want to be clear that the fact

1 that the recommendation is for a market basket for
2 hospitals this year, people should not read too much
3 into that. They should not read into it that this means
4 that hospitals will not ever -- forever more be subject
5 to a productivity adjustment. The reason that I feel
6 like this appropriate this year, or several reasons
7 actually, one is that we've seen a fairly significant
8 decline in the average margin to a level that is low
9 compared to other sectors.

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

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

21 So for those factors in combination, which I
22 think are unique to this sector, I think it's a prudent

1 step to go with a market basket increase this year for
2 both the inpatient and outpatient hospital services.
3 But again, I don't think it necessarily means that we
4 won't be back next year saying that there should be a
5 productivity adjustment.

6 MS. BURKE: I have no confusion about the fact
7 that each of these decisions is unique to this year and
8 each year is a different year. I in fact am fully
9 supportive of this recommendation. So this is not
10 because I'm concerned about what's being proposed. I
11 think it makes perfect sense.

12 It is really about helping people that don't
13 have the benefit of this conversation to understand why
14 there is consistency in what appears to be an
15 inconsistent set of decisions. Why in fact it makes
16 perfect sense for exactly the reasons you suggest. I
17 think it is simply incumbent upon us -- I think we
18 presume that people know or understand perhaps more than
19 perhaps they do when they read what it is that we've
20 said. I think this year particularly we have to be
21 careful about creating the right understanding of what
22 our intentions are and why we got where we got. It's

1 just the one further step to explain the decisions. But
2 I am perfectly comfortable with the decision that's been
3 proposed.

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

18 If Julian's summary of the access, quality,
19 service volume data, that ought to tell us there's
20 nothing obvious to worry about here. There is
21 uncertainty, but there's not something going on on
22 either the beneficiaries' access to care or the quality

1 side which suggests that prices are wildly out of line.
2 Instead we've fallen back on this unstated assumption
3 that there is some level of Medicare margin that is too
4 low. It's unstated because we don't have the vaguest
5 idea what that is. This is instinct. I don't think
6 that works.

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

16 MR. HACKBARTH: Dave, what recommendation
17 would flow?

18 MR. SMITH: I don't know, and it's the reason
19 I will support this recommendation. But I do think it's
20 an agenda that has got to get higher on our plate, is
21 trying to figure out the rationale, or conclude that
22 there is no rationale, why we so focus on Medicare

1 margin as a proxy, apparently focus on Medicare margin
2 as a proxy for quality and access even when the quality
3 and access data that we have different doesn't suggest
4 that these two are moving in sync at all.

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

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

1 we're measuring a very difficult area we shouldn't be
2 able to capture differences in a very difficult area
3 that quickly.

4 We even, as we've discussed with our three-
5 year lag in cost data, we have enough anxiety about that
6 at times as to how one runs that forward from a three-
7 year old base each time. So I think there's good
8 reason, as Bob has suggested, to worry about our ability
9 to capture access and quality very quickly. At the same
10 time I agree with David's point, it's an evolving field.
11 Obviously if one has spent 50 years trying to get cost
12 reports to work, one can't assume that access and data
13 can be nurtured and made mature in a five to 10-year
14 period. I think it's going to take a while -- maybe not
15 50 years but it's going to take a while to have the
16 quality information that's really only been focused on
17 I'd say in a four to six-year period to be anywhere near
18 the level we want it to be.

19 DR. WOLTER: The comment that the overall
20 margins are adequate in aggregate I just think over time
21 needs a little clarification, because is 1.8 percent
22 adequate in aggregate? Is 1.5, is 2.0? I don't know

1 what the right number is and I know we don't have that
2 fleshed out here. But I worry about it because we would
3 then either be targeting to get everybody to 1.8 percent
4 in these subsectors perhaps and feel that that's okay or
5 something else. I'm really not sure what the policy
6 implications of that are because we're obviously
7 concerned that there are institutions within this
8 aggregate 1.8 percent, half of them, who have negative
9 margins that seems to be influencing our decision on the
10 productivity factor this year. So it's just a question
11 that I wonder where we might go with over time.

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

1 versus inpatient. But I think at some point we might
2 want to clarify where we want to take that discussion.

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

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

1 judgment call.

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

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

19 I think some comments about the margin is 1.8
20 or whatever it is, what does that tell you? What's the
21 difference how low it is, what does it tell us about
22 what we really need to know? If we take that approach I

1 think we should be disinterested. That is, I think we
2 would have to say that there is no margin that's too
3 high as well as no margin that's too low, and I don't
4 think that's what I here. What I hear is when the
5 margins are high, they're too high. And when the
6 margins are low, it's what does this really tell us? So
7 I think we need to be careful about that.

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

13 I wanted to emphasize that I think the margins
14 are interesting if for no other reason to watch the
15 trend of them over time. Maybe not to make the
16 individual annual decision based on them as we're urged
17 to do when they're low and we're urged to neglect them
18 when they're high. But to look at the trends over time.
19 I thin that does tell you something about what's going
20 on in the sector and I think it tells you something
21 about my favorite hobbyhorse, which is access to
22 capital.

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

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

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

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

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

18 DR. NELSON: I'm uncomfortable with our
19 apparent inconsistency here. Elsewhere in our report
20 we're going to explain and justify why we believe
21 productivity should be applied to these other segments.
22 So I'm uncomfortable then with us plugging in

1 productivity one year and not another year based on what
2 the circumstances are. It seem to me we ought to try
3 and have a uniform approach that we apply as broadly as
4 we can and as consistently from year to year, and we do.
5 The first question we say, are payments adequate
6 currently, or are Medicare payments in 2004 adequate?

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

16 MR. MULLER: Alan has expressed what I feel as
17 well because we have the framework of payment adequacy
18 plus update in a variety of areas today and in other
19 years when we have margins of 10, 12, 15 percent in
20 SNFs, et cetera, and so forth we say, payments adequate
21 and we probably don't need an update and we vote not to
22 give updates. In an area here where there's, I think

1 some could argue that 1.8 is not adequate we've, in a
2 sense, taken the -- as Alan has said, we've basically
3 taken the productivity and used that as a way of dealing
4 with the adequacy issue. In other words, instead of
5 saying, let's make them adequate and then you can do the
6 update minus productivity.

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

1 than the update.

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

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

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

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

11 MR. HACKBARTH: Other reactions to that
12 proposal?

13 MR. SMITH: For reasons of consistency and
14 clarity I think Alan's proposal makes awfully good
15 sense. It does get us closer, Alan. I don't know
16 whether it's a negative implication or not. I know it's
17 an implication we will be asked subsequently to wrestle
18 with is, okay, you have implicitly stated that 1.8 is
19 too low? What about 3.8 or 15.4? We are sliding --
20 Bob, you're right it is a judgment call and we ought to
21 make it.

22 DR. REISCHAUER: It has a lot of different

1 dimensions and we don't want to give particular weight
2 to one or the other.

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

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

13 MR. HACKBARTH: Julian?

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

1 to.

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

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

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

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

22 MS. RAPHAEL: You have sectors here like

1 nursing homes and home health that have very small total
2 margins but high Medicare margins. Here you're saying
3 we have the reverse, we have higher total margins and
4 lower Medicare margins. So what does that lead you to
5 do in terms of a consistent stance?

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

9 MR. MULLER: Some of this goes back to the DSH
10 discussion of prior years where one of the reasons you
11 have this inverse relationship between Medicare and
12 total is that hospitals that had high Medicaid had lower
13 total margins. By having an DSH payment as a matter of
14 policy it drives up your Medicare margin. So in a
15 sense, a policy judgment has been made to drive up the
16 Medicare margin because you have a low total margin
17 because you have Medicaid.

18 So I would say there's a real policy reason
19 for that inverse relationship by and large because the
20 reason you have low total margins is high Medicaid and
21 high uninsured. So I don't agree with your hypothesis
22 at all. I think there's a real policy reason for that

1 relationship that has been well-established for however
2 long DSH has been around.

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

14 MR. MULLER: But you're showing 1.7 for 2002.
15 I think Carol and others have made the point, several
16 people have made the point there's been a trend here
17 that's going on for a while that has been going down,
18 costs have gone up for the reasons well-articulated
19 inside the chapter. So I don't think anybody is just
20 saying there's a point estimate that has hit us today
21 and we're saying, eureka, we never knew this. We've
22 been watching these trends for quite a while and whether

1 one uses Bob's metaphor of the canary in the mine, there
2 seems to be evidence accumulating over the years that
3 costs went up more in this field, and they may go up in
4 other fields as well.

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

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

1 we're showing for the two prior years.

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

11 I think I'm concerned about what Bob said
12 about the latency here, that by the time you see effects
13 in some of these dependent variables that we pointed out
14 we haven't seen, it may be too late. Things crash and
15 then it takes a while to come out.

16 I remember discussions with the administration
17 after the so-called Balanced Budget Act of '97, two
18 years into the academic medical centers were screaming
19 and the administration was saying, we don't really see
20 evidence that you've having -- this isn't changed, that
21 hasn't changed. Why don't we wait? It's a little hasty
22 to put money back in. We think it's going to be okay.

1 Then by the time things got around to getting corrected
2 a little bit there were a number of institutions that
3 were very severely affected.

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

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

20 It is a change though and I'm the sort who
21 gets nervous about making changes like this without
22 thinking them through. What I'd like to do is just

1 think through this some more tonight and what the
2 potential implications of the two approaches are before
3 we go one way or the other.

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

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

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

1 there will be some impact.

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

8 DR. WOLTER: I was just going to comment on
9 that again, Glenn. If we end up with whatever the
10 approach is at a certain number and don't comment at all
11 on the quality tie, could that be interpreted by some as
12 we're recommending that that be moved away from? We
13 just might want to think about whether or not we should
14 comment.

15 DR. NEWHOUSE: I think we should comment. I
16 think that's a good point. And I also think that we
17 ought to say that in our judgment about the update
18 factors we will ignore the effects on margins caused by
19 non-compliance with that provision. I think in practice
20 that's going to be, again, a judgment call, but I think
21 the general principle is that we want the hospitals to
22 comply with this and we're not going to, in effect,

1 float everybody up if people don't -- to the degree
2 people don't comply.

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

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

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

22 MR. HACKBARTH: Right. Let's turn to the

1 outpatient piece. Chantal.

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

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

20 The top line of this chart shows the overall
21 Medicare margin, again, our principal measure of
22 hospital financial performance because it addresses all

1 of the service lines that hospitals provide and obviates
2 some of the cost allocation problems. As Julian
3 discussed we also consider a host of market factors. As
4 Jack pointed out, the 2004 estimated overall Medicare
5 margin is 1.8. That does include the outpatient PPS
6 provisions in DIMA that I had mentioned previously.

7 You can see the trend in the outpatient
8 margins here and you may recall that we had slightly
9 different numbers presented at the December meeting. As
10 Jack alluded to, we did identify a data error in the
11 cost reports and it turned out there was a subset of
12 hospitals that did not have full outpatient charges
13 reflected in their cost reports. We understand from CMS
14 that this was an error stemming from difficulties some
15 FIs experienced in processing claims and generating the
16 PS&R reports. The PS&R report is the source of charges
17 for the cost reports. Due to the omission of these
18 charges we did overestimate the outpatient margins for
19 2002 in December. The final estimates presented here
20 use imputed values for the hospitals identified as most
21 likely to have had missing charges on their cost reports
22 in either 2001 or 2002.

1 So what are the numbers? There was
2 substantial improvement in the outpatient margins from
3 2000 to 2001 in the aggregate moving from negative 12.2
4 to negative 6, and this does coincide with
5 implementation of the outpatient PPS. The kinds of
6 factors that would lead to the improvements in the
7 margins are the transitional corridor payments which
8 were designed to temporarily add money to the system.
9 We did have pass-through payments that were exceeding
10 their budgeted cap in 2001. We also see from our own
11 analysis that outlier payments exceeded their cap in
12 2001.

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

17 As you can see, the margins then declined
18 between 2001 and 2002 moving from negative 6 overall to
19 negative 8.2. Again several factors explain the
20 decline, most obviously the cost growth that we've been
21 discussing which, of course, would cut across service
22 lines I think. We had lower transitional corridor

1 payments in 2002 by design and the pass-through payments
2 were subject to a pro rata reduction in 2002, and we saw
3 outlier payments more in line with their cap in that
4 year as well.

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

14 As Julian noted we do have some uncertainty as
15 we move into our decision-making process and we do have
16 evidence that cost pressures are easing, but we do not
17 know exactly how quickly. There are some issues on the
18 payment side as well. Consequently, we propose making
19 the same recommendation for the outpatient PPS as the
20 inpatient, and that would be that the Congress should
21 increase payments for the outpatient PPS by the increase
22 in the hospital market basket for calendar year 2005.

1 This recommendation is the same as current law and we
2 anticipate no implications for beneficiaries or
3 providers.

4 MR. HACKBARTH: Questions, comments?

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

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

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

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

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

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

22 DR. NEWHOUSE: I actually didn't frame it for

1 myself the way you framed it, was it step one or step
2 two. It could in principle be either. I was going to
3 go home and think about. But so in response to you is,
4 whatever the answer to that question is I would make it
5 for inpatient and outpatient.

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

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

1 can take that up tomorrow.

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

12 MR. HACKBARTH: Any other comments about
13 outpatient?

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

18 MS. COYLE: I'm sorry, if I could, just 30
19 seconds. I was trying to get around and back in your
20 standing-room only audience. Carmela Coyle, from the
21 American Hospital Association.

22 I really wanted to offer two thoughts for the

1 Commission's future consideration, but given that the
2 votes didn't occur today I now have to throw in just a
3 little note up front. That is as we take a look at both
4 the hospital inpatient and outpatient data that's just
5 been presented, costs are up, hospitals' financial
6 performance is down, the performance trend is on the
7 decline, and as staff has just suggested to you, 50
8 percent of hospitals have negative Medicare margins. So
9 we would strongly encourage this commission to vote for
10 full updates on both the inpatient and the outpatient
11 side tomorrow.

12 But two thoughts for the Commission for their
13 future consideration. Number one, we would strongly
14 encourage the Commission to again revisit the update
15 framework, especially as it relates to the application
16 of the productivity targets that have just been the
17 object of conversation this afternoon. Number one, a
18 suggestion that you discuss and revisit the premise of a
19 productivity target. And number two, specifically the
20 estimation of that target. Clearly it's an important
21 issue. It's important beyond the hospital setting, in
22 the home health SNF setting. And given the conversation

1 today would strongly encourage that you do that.

2 Second, I guess listening from the perspective
3 of the audience I think the discussion this afternoon
4 really illustrated the variation in performance, and you
5 talked a lot about that, under these various prospective
6 payment systems, and the difficulty that that presents
7 in assessing payment adequacy. May just respectfully
8 suggest that perhaps some of these issues really lead to
9 the question of whether this prospective payment systems
10 are really functioning adequately. And a thought and
11 would offer some help, we as the American Hospital
12 Association have actually convened a group of what we
13 hope are some thoughtful people to carve out time -- and
14 I know that's the hardest part of your jobs here -- but
15 to carve out some time and to really begin taking a look
16 at might there be some new payment approaches, some new
17 payment systems where the focus is the provision of
18 efficient care?

19 I don't know -- I know this is an incredibly
20 busy commission. You've got lots of reports that really
21 drive your agenda -- whether that may be an opportunity
22 for a future retreat discussion, if not this year

1 perhaps into the future. But again, just listening,
2 some of what you've talked about here illustrates maybe
3 these systems after at least 20 years on the inpatient
4 side may not be serving us as effectively and adequately
5 as could be. So would just offer that up for your
6 consideration. Thank you.

7 MR. HACKBARTH: Okay, we're adjourned and we
8 reconvene at 9:00 a.m. Thank you.

9 [Whereupon, at 4:59 p.m., the meeting was
10 recessed, to reconvene at 9:00 a.m., Thursday, January
11 15, 2004.]

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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.

Thursday, January 15, 2004

9:15 a.m.

COMMISSIONERS PRESENT:

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

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1 P R O C E E D I N G S

2 MR. HACKBARTH: Good morning.

3 I'm sorry for the delay. Let me quickly
4 review what we're going to do this morning. The first
5 thing we're going to take up this morning is a piece of
6 business left over from yesterday, which is to vote on
7 the hospital recommendations for inpatient and
8 outpatient, and that's the reason for the delay right
9 now. I want to make sure we've got all the
10 commissioners here for that vote.

11 Once we finish that, we will then turn to the
12 published agenda, which includes outpatient PPS, outlier
13 policy, ambulatory surgical centers, long-term care
14 hospitals research agenda, and dual eligible
15 beneficiaries, some analytic work that's going on there.

16 So we are going to wait to get the couple
17 commissioners I know are here in the building in the
18 room for the vote.

19 Rather than sit here waiting for people, what
20 I'm going to do is let's do the outpatient PPS outlier
21 discussion and then right after that we will turn to the
22 hospital vote. It just doesn't make sense to waste time

1 sitting here waiting for people to come in.

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

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

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

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

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

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

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

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

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

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

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

22 Finally, the outpatient PPS is the only

1 ambulatory setting with an outlier policy. However,
2 many of the services provided can also be provided in
3 physicians' offices or ASCs, and so having an outlier
4 policy in one setting and not the other creates one more
5 difference in how the services are paid across settings.

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

12 In 2002, as in 2001, a relatively small number
13 of APCs, 21, accounted for 50 percent of the outlier
14 payments. These same services accounted for only 36
15 percent of the APC payments. Among those 21 services,
16 only one, a cataract surgery, had a payment rate over
17 \$400.

18 This slide shows some of the specific services
19 that accounted for a large share of the outlier payments
20 in 2002. The order of services did change between 2001
21 and 2002 but very similar services appeared in both
22 years. For example, x-rays ranked third in 2001 but are

1 first in 2002. Electrocardiograms ranked fifth in both
2 years. These eight services accounted for 29 percent of
3 the outlier payments but only 17 percent of the APC
4 payments. Again, payment rates are low.

5 This table groups the services by their
6 payment rate and shows what share of outlier and APC
7 payments went to the services in each payment band. You
8 can see that services with payment rates of less than
9 \$50 accounted for 24 percent of the outlier payments but
10 only 11 percent of the base APC payments. Altogether 75
11 percent of outlier payments went for services costing
12 \$300 or cost and these services accounted for about 54
13 percent of the base APC payments.

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

21 In the last presentation, and in your briefing
22 papers, we looked at the distribution of outlier

1 payments by hospital group and noted that hospitals in
2 large urban areas, teaching hospitals, and for-profit
3 hospitals got larger shares of the outlier payments than
4 they did of base APC payments. These hospital groups
5 also received a greater share of their total payments
6 through the outlier mechanism. Those patterns held in
7 both 2001 and 2002.

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

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

1 payments through the outlier mechanism. As a group --
2 yes.

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

6 DR. WORZALA: Well, this is an outpatient.

7 MR. DeBUSK: It could still be capacity.

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

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

12 DR. ROWE: [off microphone.] These are the
13 larger outpatient facilities seeing give times as many,
14 10 times as many patients.

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

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

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

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

1 outlier payments. It's looking at outliers as a share
2 of their total payments.

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

8 DR. WORZALA: Yes.

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

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

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

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

21 So we saw from our hospital group analysis
22 that teaching hospitals have a greater reliance on the

1 outlier payments than other groups. The major teaching
2 hospitals in 2002 received 2.4 percent of their payments
3 as outliers compared to 1.7 percent for all. And I
4 should note 1.6 percent for other teaching hospitals.

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

9 So what we did was to repeat the previous
10 analyses for the sub-group of teaching hospitals and we
11 did find that they had a similar distribution of outlier
12 payments by service as all hospitals did. X-rays
13 accounted for the greatest share of outlier payments to
14 teaching hospitals, about 4 percent. Similarly,
15 services with low payment rates, \$50 or less, accounted
16 for 24 percent of the outlier payments. The services
17 with the highest payment rates, those over \$1000, did
18 not account for a large share of the outlier payments
19 received by teaching hospitals, 8 percent.

20 We also looked at the distribution of outlier
21 payments among teaching hospitals and found a similar
22 level of variation as we did for all hospitals. The

1 bottom half of teaching hospitals received 16 percent of
2 the outlier payments while the top 10 percent received
3 42 percent.

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

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

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

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

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

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

9 I got the feeling as I started reading it that
10 somehow differently from other chapters that we've done
11 where we've made major recommendations, we sort of
12 started with our mind made up. And I don't know that
13 the analysis and the process that we got there, but it
14 just sort of the way it was worded or my conclusions.

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

21 I don't think we do as good a job and I think
22 we need to spend a little bit more time of either

1 assuring policymakers, including ourselves, that yes,
2 that will or will not in fact impact access for the
3 fragile or the complex on the outpatient basis.

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

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

18 DR. ROWE: Can I ask Bob a question about the
19 budget observation? If the implementation of the
20 outlier policy resulted in increase in expenses, let's
21 say from X to X plus Y, if we get rid of the outlier
22 policy does that mean that the total amount of money

1 that's going to be distributed across hospitals is X
2 plus Y? Or do you think it would go back to X? In
3 which case it would actually be a savings by getting rid
4 of the so-called budget neutral outlier policy?

5 DR. REISCHAUER: It would go back to X,
6 because what happens now is the Secretary says I expect
7 outlier payments to be 2 percent of the total, sets the
8 parameters so as to meet that total. It turns out to be
9 3 and the trust fund or the S&I trust fund eats 1
10 percent and we never go back.

11 DR. ROWE: Thank you, because I was thinking
12 that an alternative that somebody might say is okay, you
13 want it to be budget neutral. We'll take the amount
14 that was spent last year and we'll distribute it across
15 the hospitals, which was therefore budget neutral. But
16 that has already embedded in it the Y component, which
17 was the increase associated with the implementation of
18 the outlier policy.

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

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

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

16 It could be that teaching hospitals are
17 cruising down this curve at a faster rate than the
18 average, as are for-profit hospitals and things like
19 that. And then, when you threw in a teaching/non-
20 teaching variable it would be insignificant. But we
21 could go through this and think exactly what it is that
22 we think produces this kind of behavior. And in the

1 best of all possible worlds, it would be teaching
2 because the teaching would have more complex cases and
3 more variability in those cases and all of that. But
4 when we look at this aggregate data, it doesn't look
5 like that's the case.

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

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

20 DR. REISCHAUER: About those or about
21 variability of cost-to-charge ratios within subgroups of
22 categories of services is greater in those hospitals.

1 Who knows?

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

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

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

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

1 neutrality.

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

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

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

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

22 DR. WORZALA: That's correct.

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

3 MS. DePARLE: Yes.

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

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

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

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

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

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

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

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

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

22 MR. DeBUSK: Chantal, Glen, is this system

1 working now the way it is? Is it broke?

2 MR. HACKBARTH: The outlier piece, yes, that's
3 the gist of the recommendation, that it is broke.

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

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

17 MR. HACKBARTH: I'm not sure, Pete, that I'm
18 following. The gist of what we're recommending is that
19 this is broken because it's putting a lot of outlier
20 additional payments focused on services with very small
21 bundles and low unit prices and that's not consistent
22 with the basic concept of an outlier system. It's not

1 getting the money to the right place. We'd be better
2 off putting the money in the base rate as opposed to
3 having this distribution that this system is producing.

4 MR. DeBUSK: Maybe so.

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

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

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

21 DR. REISCHAUER: But nobody pays charges. A
22 few Saudi Arabians fly in and pay charges but CareFirst

1 and Aetna and those people aren't paying charges.

2 DR. NELSON: I guess I don't understand the
3 rationale for this being utilized for relatively low-
4 cost services as duh. I guess what I'm saying is why
5 doesn't the whole world do that if it is, as it appears,
6 a potential license to steal? What is the restriction?
7 Why is it only such a low percentage? Help me
8 understand.

9 DR. WORZALA: I believe, and please help me
10 those of you who run private insurance companies, I
11 don't know that any other purchaser would have any kind
12 of outlier or -- I'm not getting the word in my head --
13 but any kind of additional payment for low-cost
14 services. They will have a stop-loss provision but it's
15 \$100,000 or something like that. So none of this kind
16 of outlier additional payment would accrue to any
17 outpatient service that I'm aware of.

18 DR. ROWE: Depending on the way the contracts
19 are written, you can be subject to autonomous increases
20 in charges on the part of the hospitals, just to rev up
21 their chargemaster payments and stop-loss provisions are
22 generally being removed from hospital contracts. Or

1 many private insurers sell stop-loss insurance as well
2 was regular insurance so it gets very complex. I think
3 that the private insureds are less vulnerable than the
4 Medicare system in general and becoming increasingly
5 less vulnerable all the time because of changes in the
6 way the contracts are written.

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

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

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

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

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

5 Okay, thank you.

6 Let's now turn to the hospital update
7 recommendations. Yesterday we had a lengthy discussion
8 and I'd characterize it as follows: I think there was
9 agreement on the substance of what we ought to do, which
10 is to recommend a market basket increase for both the
11 inpatient and outpatient rates, but varying ideas about
12 how to characterize why we're doing that step.

13 What I'd like to do is just go back and review
14 a couple of things and offer a formulation that we would
15 include in the body of our report and this benefits from
16 many conversations that I've had with individual
17 commissioners.

18 Let me begin when the payment adequacy
19 framework. We have a two-step process where we look at
20 the adequacy of the rates and then a second step that
21 looks at how much they ought to be increased for the
22 next year. In that second step, we of course include

1 the estimated increase in the hospital market basket and
2 then two additional elements. One, an expectation for
3 improvement in productivity. And then second, an
4 allowance for cost increasing but quality enhancing
5 technology.

6 In talking to commissioners about this before
7 and after yesterday's meeting, it's clear to me that
8 people believe that these are reasonable and appropriate
9 steps, the expectation for productivity and the
10 allowance for new technology. I think that they are
11 reasonable and we ought to continue them in the future.

12 Let me focus for a second on the productivity
13 adjustment in particular. As we say, it's an
14 expectation that there will be continued efforts and
15 success in improving productivity. But beyond that it's
16 a statement that the taxpayers ought to share in those
17 gains. As I see it, simply what we're trying to do here
18 is mimic what would happen in a competitive market
19 where, in fact, the purchasers do share in the gains
20 from improved productivity.

21 So the framework I have been comfortable and I
22 continue to be comfortable with and expect to retain it

1 into the future.

2 Now having said that, I think for 2005 it
3 would be a prudent step to forego making those
4 adjustments or productivity and technology. Not abandon
5 them, but prudent to forego them for this year's
6 recommendation. Why is that? I think we face a complex
7 and changing picture, one that's a little different than
8 at least we've faced recently when examining hospital
9 financial performance. And not all of the indicators
10 point in the same direction, which is part of the reason
11 that it's so challenging and complex.

12 As part of our analysis we, yes, of course,
13 look at hospital margins but we look at other factors as
14 well in making our determinations about payment
15 adequacy, including access, quality of care, what's
16 happening with access to capital and capital investment.
17 And not all of the signals are in the same direction.
18 Yes, we have evidence of declining margins but access to
19 care continues to be good. Generally, the information
20 on quality is good although there are some exceptions to
21 that. There's been a significant increase in capital
22 investment which would suggest that hospitals and

1 lenders are feeling reasonably good about their
2 prospects.

3 We do have, however, a significant decline in
4 the margin, the projected margin, and a fair amount of
5 uncertainty about cost trends, and even some degree
6 payment trends as a result of provisions in the drug
7 reform legislation, that in my judgment at least create
8 more than the usual amount of uncertainty.

9 So given that complex picture, as I say, I
10 think the prudent thing to do is not to abandon our
11 framework but rather for this year to forego the two
12 adjustments, one for productivity and the other for
13 technology. We will continue to examine the data, try
14 to better understand what's happening with the cost
15 trends, examine the somewhat different distribution of
16 winners and losers that we have now than we've had in
17 the past. As always, this is an ongoing process. We're
18 not making a decision for all time but rather one that
19 we will necessarily come back to again next year.

20 So that's my thinking about why this is the
21 appropriate recommendation and I'd open it up to
22 discussion. Nancy Ann?

1 MS. DePARLE: I thought about this a long time
2 last night and reread the materials and I think for all
3 the reason you stated --- I won't repeat everything you
4 said -- but that this is the best place for us to be.

5 I thought the discussion yesterday was helpful
6 and informative and useful. But I think the better way
7 to handle this is just in our explanation of the chapter
8 to give some of the details that you've articulated as
9 opposed to trying to change the recommendation around
10 and get into the adequacy of payment on those issues.
11 So I would strongly support moving forward with that
12 recommendation.

13 MR. HACKBARTH: Any other thoughts? Okay,
14 let's proceed to the vote then.

15 All opposed to the recommendation? All in
16 favor? Abstentions?

17 Okay, thank you.

18 MS. RAPHAEL: What about the outpatient?

19 MR. HACKBARTH: All opposed to the outpatient
20 recommendation? All in favor? Abstentions?

21 Okay, thanks, Chantal.

22 Next up is ambulatory surgical centers.

1 MR. WINTER: Good morning.

2 I'll be reviewing our assessment of payment
3 adequacy for ASC services and our draft recommendation
4 for updating payment rates for 2005.

5 I'll also be discussing draft recommendations
6 on revising the ASC payment system and the process by
7 CMS decides which procedures to pay for in an ASC.

8 I will quickly review our analysis of payment
9 adequacy based on the following four factors: it
10 appears that beneficiaries have good access to
11 ambulatory surgical services. The number of ASCs has
12 significantly expanded over the last several years. In
13 addition, the number of beneficiaries receiving ASC
14 services grew by 14.5 percent per year on average
15 between 1998 and 2002.

16 Next, we'll look at the increase in the supply
17 of providers and some new data that we've been working
18 on to characterize ASCs. We're going to move on to a
19 couple of other slides and come back to the framework in
20 a couple of minutes.

21 So as of June 2003 there were over 3,700
22 Medicare certified facilities, an increase of 50 percent

1 from 1997. Most of the new and older ASCs are for-
2 profit freestanding providers located in urban areas.

3 At the Commission's, request we attempted to
4 identify ASCs by the types of services they provide. We
5 based our analysis on Medicare claims from 2002. We
6 encountered some data problems that limited the scope of
7 our study, but I'll present what we were able to find.
8 To ensure that we had an adequate number of claims to
9 characterize each ASC, we selected ASCs with about 1,000
10 total claims. About 1,150 ASCs met this threshold,
11 which is about one-third of all ASCs. These high-volume
12 centers accounted for two-thirds of Medicare volume and
13 payments to ASCs. We defined an ASC as single specialty
14 if at least 90 percent of its Medicare payments were
15 related to one physician specialty, such as
16 ophthalmology or gastroenterology. We found that over
17 half the centers met this definition of single
18 specialty.

19 This table shows the number of ASCs in each
20 specialty category as well as each categories' share of
21 high-volume centers and Medicare payments. There's an
22 error in the bottom row under the column percent of

1 high-volume ASCs. those numbers should sum to 99 rather
2 than 95, as shown.

3 Over 40 percent of high volume ASCs were in
4 the general category which means that fewer than 90
5 percent of their payments were related to one specialty.
6 However, most of the general ASCs received a majority of
7 their Medicare revenue from ophthalmology or GI
8 procedures. One-third of ASCs specialized in eye
9 procedures and almost 20 percent in gastroenterology
10 procedures. Although we are unable to identify the age
11 of each ASC, 90 percent of these facilities submitted
12 Medicare claims in the previous year.

13 The next question is whether Medicare's share
14 of an ASC's volume or revenue varies by its specialty
15 type. Unfortunately, the most recent source of data on
16 Medicare share of overall volume by service is from
17 CMS's 1994 survey of ASCs. This reinforces the
18 importance of collecting more recent ASC data.

19 The survey data show that Medicare accounted
20 for 40 percent of all services covered by Medicare in an
21 and ASC. Medicare's share of ophthalmology procedures
22 was about 75 percent and its share of GI procedures was

1 about 40 percent.

2 Now we're going to go back to our update
3 framework on slide two. We're now going to be on the
4 third bullet. We found rapid growth in the volume of
5 services provided by ASCs to beneficiaries. Between
6 1998 and 2002 annual growth of ASC services averaged 15
7 percent. By comparison, there was about 2 percent
8 average annual growth of ambulatory surgical services in
9 outpatient departments over the same period.

10 Finally, we found that ASCs have sufficient
11 access to capital. These factors suggest that
12 Medicare's payments to ASCs are more than adequate to
13 cover current costs.

14 In the next part of the update framework we
15 look at changes in the unit cost of ASC services for
16 fiscal year 2005. The ASC payment system uses the
17 consumer price index for urban consumers to approximate
18 changes in input prices. The CPI-U is currently
19 projected to increase by 2.4 percent in FY 2005. This
20 is a more recent number than appears in your mailing
21 materials. As with other provider sectors, MedPAC sets
22 a policy goal for productivity growth of 0.9 percent.

1 Subtracting productivity growth from input price
2 inflation results in an increase of 1.5 percent in the
3 unit cost of ASC services. We believe that current base
4 payments are at least adequate to cover this increase in
5 cost.

6 Thus, our draft update recommendation is that
7 there should be no update to payment rates for ASC
8 services for fiscal year 2005. It is based on our
9 conclusion that current Medicare payments to ASCs are
10 more than adequate to cover current costs and are at
11 least adequate to cover a 1.5 percent increase in next
12 year's costs. Because this would reflect current law,
13 they would be no spending implications. And we do not
14 believe that this would affect ASCs' ability to provide
15 services to beneficiaries.

16 The next question we'll look at is how to
17 revise the ASC payment system. The new Medicare law
18 requires the General Accounting Office to study the
19 appropriateness of using the outpatient PPS procedure
20 categories and relative weights for the ASC system. The
21 law requires the Secretary to implement a revised ASC
22 payment system no earlier than 2006, fix taking into

1 account the GAO report. I will quickly review the main
2 issues involved in basing the ASC payment system on the
3 outpatient system.

4 Using the outpatient procedure groups would
5 expand the number of payment groups for ASC services,
6 which could enhance the accuracy of ASC payments. There
7 are significant variation among rates in ASCs and
8 outpatient departments for some surgical services which
9 could create financial incentives for providers to shift
10 services to the profitable setting. Using the same
11 grouping of services and weights in the ASC and
12 outpatient payment systems would likely make the weights
13 more comparable, thus minimizing these financial
14 incentives.

15 Due to competing agency priorities and
16 Congressional action, CMS has not implemented revisions
17 to the ASC system since 1990. Linking the two systems
18 would allow CMS to update ASC procedure groups and
19 weights each year, along with its annual revisions to
20 the outpatient PPS. This should reduce the long delays
21 between revisions to the ASC system.

22 However, this approach does raise some

1 concerns. The outpatient weights may not reflect the
2 relative costs of individual services which could have a
3 large impact on ASCs that specialize in a narrow range
4 of procedures. Given data limitations, however, it
5 doesn't seem practical to set separate rates for each
6 individual procedure.

7 Another concern is that currently base rates
8 in each payment system sometimes cover different bundles
9 of services. For example, outpatient departments may
10 receive additional pass-through payments for new devices
11 which ASCs do not receive. On the other hand, ASCs can
12 bill separately for prosthetic devices used in surgical
13 procedures unlike outpatient departments. When CMS
14 revises the ASC payment system, it should address these
15 variations.

16 If we use the outpatient weights for the ASC
17 payment system, how should we set the conversion factor
18 or average payment amount? The new Medicare law
19 requires that total payments under the new system be
20 equal to total projected payments under the old system.
21 Thus, the conversion factor would be based on the level
22 of payments under the old system, which may not reflect

1 ASCs' costs.

2 One of the Commission's principles is that
3 Medicare payment rates should reflect the costs incurred
4 by efficient providers. If the conversion factor is to
5 reflect costs of efficient ASCs, then CMS will have to
6 collect recent ASC cost data.

7 This leads us to our next draft
8 recommendation, which has three parts. First, the
9 Secretary should revise the ASC payment system so that
10 its relative weights and procedure groups are consistent
11 with those in the outpatient prospective payment system.

12 Second, the Congress should require the
13 Secretary to periodically collect ASC cost data to
14 monitor the adequacy of ASC rates and develop a
15 conversion factor that reflects the cost of ASC services.
16

17 Third, the Congress should ensure that payment
18 rates for ASC procedures do not exceed outpatient PPS
19 procedures for the same procedures, accounting for
20 differences in the bundle of services. Thus, outpatient
21 rates would be the ceiling for ASC rates, even if we
22 find that ASCs incur higher costs.

1 We are unable to estimate the spending
2 implications of this recommendation. ASC rates that are
3 currently higher than outpatient rates would decline,
4 while ASC rates that are significantly lower than
5 outpatient rates would probably increase and it's
6 unclear how these changes would offset each other.

7 We also cannot predict the net impact on
8 beneficiaries cost sharing. Our recommendation assumes
9 that co-insurance would remain at 20 percent of the
10 total ASC payment rates. The co-insurance amount would
11 increase for services where the rates increase and
12 decline for services where the rates decline.

13 In terms of provider implications, ASCs that
14 focus on services that are currently paid more in ASCs
15 than outpatient departments would experience payment
16 reductions. However, ASCs that provide services
17 currently reimbursed at much lower levels, such as some
18 orthopedic procedures, might receive higher payments.

19 The next issue is how CMS decides what
20 procedures to pay for in an ASC. CMS is required by
21 statute to maintain a list of services that are payable
22 by Medicare in an ASC. Procedures must meet several

1 criteria to be placed on the list. They must be
2 performed in inpatient settings at least 20 percent of
3 the time but cannot be performed in physician offices
4 more than 50 percent of the time. They cannot exceed
5 certain time limits for surgery, anesthesia, and
6 recovery, and they also have to meet certain clinical
7 safety criteria. For example, a procedure is excluded
8 if it results in expensive blood loss.

9 Although CMS is required to update the list
10 every two years, it was not updated between 1995 and
11 March 2003. Long gaps between updates make it difficult
12 for the list to keep pace with technological changes
13 that enable ASCs to safely provide additional services.
14 Some of the criteria, such as the volume of a service in
15 inpatient settings, may no longer be relevant for
16 determining what services are clinically appropriate to
17 perform in an ASC.

18 Instead of maintaining a list of services that
19 are eligible for payments, it might make sense for CMS
20 to create a list of services that are specifically
21 excluded from payment. For example, CMS maintains a
22 list of inpatient only services that are excluded from

1 payment in hospital outpatient departments. When
2 considering what ASC services to exclude from payment,
3 CMS should continue to apply clinical safety standards.
4 It should also exclude services that are likely to
5 require an overnight stay to ensure that ASCs only
6 perform ambulatory procedures.

7 To avoid creating financial incentives for
8 services to shift from physician offices to ASCs, CMS
9 should exclude procedures that are routinely performed
10 in physician offices and would be paid significantly
11 more in an ASC.

12 We propose recommending that after the ASC
13 payment system is revised, the Congress should direct
14 the Secretary to replace the current list of approved
15 ASC procedures with a list of procedures that are
16 excluded from payment based on clinical safety
17 standards, whether the service requires an overnight
18 stay, and payment differences between ASCs and physician
19 offices. We propose that this changes occur only after
20 CMS has revised the ASC payment system and reduced
21 payment disparities between ASCs and hospital
22 departments.

1 There are two main goals of this
2 recommendation, to give physicians greater discretion
3 over where to provide a service, and to make it easier
4 for ASCs to keep up with changes in clinical practice
5 and technology that allow more services to be safely
6 provided in ambulatory settings. There is a risk that
7 if the list is not kept up to date, this change might
8 encourage the migration of some procedures to ASCs that
9 are inappropriate for beneficiaries in that setting.
10 However, ASCs have to meet minimal safety and quality
11 standards to obtain accreditation and Medicare
12 certification, which should mitigate this risk.

13 This recommendation could increase Medicare
14 spending if more surgical services over all are
15 performed beyond the shift of services from other
16 settings to ASCs. Of the other hand, if ASCs are paid
17 less than outpatient departments under a revised system,
18 Medicare spending could decline if services shift from
19 outpatient departments to ASCs.

20 ASCs would likely be able to provide a broader
21 range of services, thus offering beneficiaries an
22 additional choice of setting. Beneficiaries who could

1 obtain services in an ASC instead of an outpatient
2 department would also likely have lower cost sharing.

3 This concludes my presentation and I look
4 forward to your feedback.

5 DR. NEWHOUSE: Do you want to take the
6 recommendations in order or do you want to just -- my
7 comment is on recommendation two.

8 MR. HACKBARTH: For purposes of the
9 discussion, we'll just treat them as a group.

10 DR. NEWHOUSE: Could you go back to slide
11 nine, Ariel? So what is being proposed here is that, in
12 effect, we take the outpatient PPS payment system with a
13 different conversion factor. What I'm concerned about
14 is that the weights is the first concern there, the
15 weights may not be right. The reason I'm concerned
16 about it is that we have all of these single specialty
17 ASCs. In the outpatient side, the joint costs that go
18 across different procedures get spread around into the
19 weights. Those may not be appropriate for the ASC.

20 I don't have a problem with going with the
21 recommendation but I would like to, although given the
22 administrative load on CMS I'm reluctant to say this,

1 but I think at some point we need to have some data on
2 what the right weights are for the ASCs, at least to
3 back up our assumption here that the outpatient weights
4 are approximately right.

5 What I'm concerned about actually is advantage
6 number two up on this slide is actually only an
7 advantage if the relative weights are correct. If the
8 relative costs in the ASC is different relative than in
9 the outpatient department we could potentially be
10 enhancing financial incentives to shift services. I
11 don't think CMS can do it now given the load it has, but
12 at some point we need to say that there needs to be some
13 real data in the system on what actually are the weights
14 that are appropriate for ASCs.

15 DR. MILLER: I think that's the second element
16 of the recommendation number two.

17 DR. NEWHOUSE: It doesn't say anything about
18 weights. I got this to get to the conversion factor
19 advocacy and not the weights.

20 DR. MILLER: That's fair but I think in some
21 of our discussions it seems to be we've gone around this
22 true a little bit. Once you get the cost data you could

1 actually go through the process of running it through
2 the OPD categories and determine how the weights
3 actually compare to the OPD weights.

4 MR. WINTER: Right. You could think of this
5 as sort of a starting place. They start off using the
6 outpatient weights in groups. And then once you get ASC
7 cost data, you could adjust, calibrate, those weights
8 based on what the data show. And the GAO study is
9 supposed to consider data submitted by the ASC industry
10 and that might also shed light on adjustments that you
11 might want to make in the weights and the procedure
12 groups.

13 DR. NEWHOUSE: Depends on what you mean by ASC
14 cost data. Obviously you need more than total cost.
15 You need some way of allocating those costs down to
16 procedures. It's not clear just from saying -- I mean,
17 you can put this in the text, but collecting cost data
18 is going to get to there. It's a puzzle. The question
19 is what kind of cost data would you collect that let you
20 set the weights?

21 DR. MILLER: For example, the GAO report that
22 mandated in the legislation to collect cost information

1 on ASCs.

2 MR. WINTER: It's supposed to consider data
3 submitted by the industry. So I guess you could do it
4 that way.

5 DR. MILLER: It's not clear that would come in
6 by procedure, for example?

7 MR. WINTER: The legislation does not specify
8 that level of details for cost data. And it did repeal,
9 eliminate the requirement on CMS to do a survey every
10 five years of ASCs' costs, which is why this part of the
11 recommendation is very important. And maybe we could
12 specify that, the Secretary should periodically collect
13 ASC cost data at the procedure level to address Joe's
14 concern.

15 DR. ROWE: Ariel, I'd like to have a little
16 more discussion about recommendation number three,
17 particularly some of the issues about excluding from
18 payment based on payment differences and some of the
19 other requirements, and the issue of what can get done
20 in a physician's office versus what can get done in an
21 ASC and what can get done in an outpatient department.

22 My experience is a little different. You

1 write about the fact that ASCs are more costly, more
2 specialized, they may be. My experience this was always
3 about a bargaining unit issue, this was a labor
4 relations issue. That, in hospitals that were
5 unionized, which is the setting that I worked in, the
6 ASC was not unionized. That the ASC was owned more than
7 50 percent by somebody else, and therefore the salaries
8 and the benefits or whatever else was associated with
9 that were very different, the input prices were lower.

10 And the doctors offices were on the medical
11 campus. And therefore the people who worked in the
12 doctor's offices were in the unit. I'm not saying
13 that's good or bad. I'm just giving you an experience.

14 So things were actually quite a bit in a
15 different direction than we maybe assuming here, in
16 terms of the cost of doing something. And I'm not sure
17 that influences the recommendation. It's one of the
18 issues here and we might want to think it through.

19 But what I want to make sure is that the
20 physicians actually really have more discretion and the
21 patients have more discretion about where to do a given
22 procedure because my feelings are that the patients who

1 get colonoscopies vary a lot, and some of them are
2 really healthy 50-year-olds who get one for their 50th
3 birthday as a screening procedures. And others are
4 frail people with a lot of diseases and comorbidities
5 and medications and you just take one look at this
6 patient and say I don't want to do this in my office.
7 But they look the same to Medicare from the point of
8 view of the charge or whatever.

9 So just explain to me that we're not excluding
10 paying for a procedure to be done in an ASC just because
11 it could be done in a doctor's office and the doctor
12 prefers to do it in an ASC because of the condition of
13 the patient. Just assure me we're not doing that
14 because that's the way I interpreted this.

15 MR. WINTER: The concern here is that if you
16 allow more procedures to be done on particularly more
17 basic procedures that may not require the specialized
18 setting of an ASC, such as a dedicated operating room
19 and recovery room, that you might encourage physicians
20 to open up an ASC next door to capture the higher
21 facility payments for an ASC for that procedural when
22 the additional infrastructure of an ASC may not be

1 needed for an average patient.

2 Now I understand what you're saying for a
3 sicker patient.

4 DR. ROWE: I'm looking at it from the doctor's
5 point of view and the Medicare beneficiaries. We want
6 to make sure that clinically we get this done in the
7 safest, most appropriate environment. Now it may be
8 that that environment is going to be replete with other
9 resources that aren't needed to do a safe colonoscopy in
10 an 87-year-old frail patient. But as a doctor or the
11 son of the patient or whatever, I don't care about that.
12 Just don't tell me that this guy's got to do it in his
13 office where there's no anesthesiologist around and
14 where he does two a week or something because he can't
15 get paid if he does it in the ASC. That's the way I was
16 interpreting this recommendation. Maybe I'm wrong.

17 MR. WINTER: That physician could still do the
18 procedure in the hospital outpatient department if the
19 ASC were not available.

20 DR. ROWE: Not everybody can do that. That's
21 not ubiquitously available to every practicing
22 physician. Or maybe an ASC. It varies, I guess is my

1 point.

2 I'm just trying to look at this clinically
3 rather than the financial incentives. I don't know that
4 there's a solution here. I'm just concerned about it.

5 What if the hospital outpatient department
6 stopped doing these things because they owned the ASC?
7 They just say we're not going to have this duplicative
8 redundant infrastructure and the only such-and-suches
9 we're going to do are inpatient. And if they're
10 outpatient, they're going to get done in our ASC which
11 is around the corner? Then the guy is stick, right?

12 DR. STOWERS: This may be an obvious question
13 but when you say replace it with the outpatient
14 procedure list, are you limiting that to surgical
15 procedures or are we going to throw in CAT scans with
16 contract or all the other things that are done in the
17 outpatient departments?

18 MR. WINTER: In terms of allowing them to be
19 done in ASCs?

20 DR. STOWERS: Right.

21 MR. WINTER: That's not our intention. Our
22 intention is to continue to limit the ASC procedures to

1 ambulatory surgical services and not include radiology
2 and other services.

3 DR. STOWERS: We may need to make that clear
4 because that outpatient procedure list has all sorts of
5 things on there that would really open Pandora's box
6 because there's a tremendous price difference between
7 getting a CT scan done in the outpatient department or
8 getting it done in a community x-ray center by three-to-
9 one in costs. So if we were to throw all of those into
10 this procedure list, it would totally change the
11 complexion of all of this. So we may want to make it
12 clear we're still talking just surgical outpatient
13 procedures.

14 MS. DePARLE: Generally, I think the
15 recommendations are moving in the right direction and I
16 just had a couple of comments.

17 On number three, I think I said this the last
18 time but I'll just say it again. I'm really glad that I
19 think we've come up with something that makes a lot more
20 sense than what CMS has been trying to do, and not very
21 successfully. I think this area has really been
22 neglected by CMS, for lots of reasons including the ones

1 that Joe and others have pointed out, which is that they
2 simply don't have the resources given everything else on
3 their plate to keep up with this.

4 I think what we're doing is moving this where
5 it should be, which is more towards a clinician making a
6 clinical judgment in the way that Jack described. You
7 could also make the argument, subject to Ray's caveat,
8 that anything that isn't on the inpatient-only list
9 should be open here, that is should be a matter clinical
10 judgment.

11 But in any event, I think this definitely
12 moves in the right direction.

13 Our second recommendation, I will support it
14 but I just would note that I have a slight misgiving
15 even as you've modified it in that Congress stated a
16 month ago, I guess, that this new payment system should
17 be budget neutral. My experience, from having
18 implemented a number of new payment systems, is that
19 when they are budget neutral it is far easier to get it
20 done, to work with the industry to get it done.

21 Now, you may have lots of changes underneath
22 the overall baseline spending so that some things will

1 move in one direction and some things will in another.
2 But that it's far easier to implement. And then in the
3 end you actually do get behavioral changes that move in
4 the direction that you want.

5 So while I'm not going to vote against this, I
6 do caution that that may have been why Congress chose to
7 say this thing should be budget neutral. And what we're
8 trying to do, I think, may make it more difficult to
9 achieve our objective.

10 MR. SMITH: Ariel, thank you. This was a very
11 good job.

12 I want to return to the question Jack raised
13 about recommendation three from a slightly different
14 angle. His discussion about whether or not things are
15 organized or not, I'm going to avoid.

16 But I did wonder, Ariel, why we didn't apply
17 the same principle of ceiling price that we thought
18 about with respect to OPDs and ASCs, why we didn't apply
19 the same principles to the issue of physicians' offices?
20 If we use the physician office payment as a ceiling, why
21 wouldn't we want to have the option of having the
22 procedure performed in an ASC, as well, with that

1 caveat? Partly addressing Jack's clinical concerns, but
2 also trying to establish neutrality in site of service
3 here. So we both open up the possibility of a more
4 sophisticated setting, but we don't introduce the
5 possibility of site shifting simply on the basis of
6 payment rates.

7 So unless I'm missing something, it would seem
8 to me that we ought to see if we can deal with the third
9 bullet there, the payment difference between ASCs and
10 physicians offices to apply the same ceiling principle
11 we used in the earlier recommendation with respect to
12 ASCs and OPDs.

13 MR. HACKBARTH: Ariel, do you have any
14 reaction to that idea?

15 MR. WINTER: I'm trying to think about whether
16 to add it to this recommendation or have it as a
17 separate free-standing recommendation. I guess we could
18 eliminate the third bullet under this recommendation and
19 say procedures that are routinely and safely performed
20 in physician offices can be performed in ASCs, but would
21 be paid at the physician office practice expense rate if
22 it's commonly done in the office setting.

1 MS. DePARLE: Then what would you do to --
2 there probably is some set of procedures that could be
3 performed in a hospital outpatient department, an ASC,
4 or a physician office. I think we all support the idea
5 of a level playing field here, but I don't have any
6 sense of what the impact of that would be in terms of
7 payment, do you?

8 MR. WINTER: We'd only do it for services
9 where -- one thing you could do is only set that rule
10 for services where 50 percent or more of the ambulatory
11 volume is in a physician office, but then you would
12 still have a big gap between the physician office --
13 probably a big gap between the practice expense rate in
14 the physician office and the outpatient facility rate.

15 MS. DePARLE: Right, but then are we
16 suggesting that we should lower the hospital outpatient
17 payment, if a lot of these things could be performed
18 safely in a physician office? I think that seems like
19 we're introducing a whole new, perhaps very interesting,
20 but a whole new element to this.

21 MR. WINTER: I think before we consider doing
22 that, we'd have to look at the patient mix in each

1 setting and the regulatory burdens and quality in
2 outcomes. This is part of our longer-term agenda for
3 payment differences across settings for the same
4 service. So we may want to wait and think some more
5 about that before heading into this area.

6 DR. ROWE: I think that there are the same
7 issues about what the payment scales are and the
8 benefits, and all kinds of different things.

9 MS. RAPHAEL: Ariel, just a clarifying
10 question. Why are we saying that this has to occur
11 after the ASC payment system is revised? Because I look
12 at this as a very separate set of activities that are
13 clinically driven. So I don't understand the bridge
14 between the two.

15 MR. WINTER: One of the concerns about opening
16 up the ASC list or allowing more procedures to be done
17 in ASCs that are currently being done in outpatient
18 departments is that under the current ASC payment
19 systems there are big disparities in payments in both
20 directions.

21 But we're more concerned about cases where the
22 ASC payment rate is higher than the outpatient rate. So

1 if you allowed more procedures to be done and those
2 rates ended up being higher than the outpatient rate,
3 then you might encourage the migration of procedures to
4 the ASC setting for financial rather than clinical
5 reasons. But it depends on what -- what payment group
6 would you put the new procedures in? That's the big
7 question.

8 And CMS struggled with that when they expanded
9 the list in March of last year and they ended up not
10 including new procedures on the list for that reason,
11 because they didn't know what group to put them in.
12 Even in the lowest paid ASC payment group, they would
13 still be paid significantly higher than the outpatient
14 rate. That was the issue. So based on the current
15 architecture of the ASC payment system, it could create
16 problems when you try to allow new procedures to be done
17 in the ASC setting.

18 DR. WOLTER: I also thought it was an
19 excellent chapter and the recommendation is in the right
20 direction. I have two concerns.

21 One is we state again that we would like in
22 both the ASC and the hospital outpatient setting for

1 costs of efficient providers to be covered. In one case
2 we don't have any cost data. And in the other case we
3 either don't believe it or aren't sure how to interpret
4 it.

5 And I can't help but point out once again that
6 we need to decide are we going to wrestle with that
7 issue on the outpatient hospital side as well as the ASC
8 side or not, because it leaves us in a position of
9 making decisions year-to-year based on a framework that
10 we can't really use because we don't have the data that
11 we believe.

12 My second concern, which I haven't really seen
13 raised but it concerns me. And that has to do with
14 self-referral and utilization patterns over time when
15 physicians are significant owners of a facility. I
16 don't know whether that should become part of our agenda
17 ever or whether it's being looked at by someone else.
18 But I think it's an inevitable question that's going to
19 be raised as this movement continues over time.

20 DR. ROWE: [off microphone.] These are the
21 safe harbor, the Stark privileges.

22 MR. HACKBARTH: In fact, it might be useful

1 Ariel for you to just quickly summarize what the rules
2 of the game are right now.

3 MR. WINTER: Sure. The Stark legislation
4 prohibits physician self-referral, prohibits Medicare
5 and Medicaid payments -- it prevents a physician from
6 self-referring to an entity in which they have a
7 financial stake. And there are nine health services
8 that are excluded from physician ownership but ASCs are
9 not on that list.

10 The other relevant legislation is the anti-
11 kickback law, which is much broader and covers all
12 health care services and prohibits remuneration or any
13 kind of incentive for physicians to perform a service.
14 And there are safe harbors that allow physician
15 ownership of ASCs under the anti-kickback law.

16 DR. MILLER: So the punchline is right now
17 there is an exemption in the Stark rule for the whole
18 hospital exemption, and essentially, once you troll
19 through all of this, for ASC; is that right?

20 MR. WINTER: That's right.

21 MR. HACKBARTH: That's the piece I don't
22 understand. I understand the logic of the whole

1 hospital exemption being that an individual's decisions
2 about where to send a patient are small in the context
3 of a large institution. That doesn't seem to apply to
4 ASCs which can be much smaller and very specialized. So
5 the risk that the Stark law is directed at seems to
6 exist in the case of ASCs and why are they not covered?

7 MR. WINTER: I think the logic initially was
8 that when the Stark law was enacted in the early 1990s,
9 actually the first one was 1989, the government was
10 trying to encourage the growth of ASCs because they were
11 seen as a less costly alternative to outpatient
12 departments and inpatient hospital settings. And most
13 ASCs at the time were owned by physicians. They were
14 the main source of capital for ASC development. So if
15 you prohibited physician ownership of ASCs, you limit
16 the growth of ASCs. And that was the concern in the
17 late '80s. And the market has obviously changed a lot
18 since then so it might be worth revisiting.

19 MR. HACKBARTH: I'm with Nick on this. I have
20 some concerns about that issue as well and whether the
21 current rules make sense in the world as we now know it.

22 DR. ROWE: I think practically, it's quite

1 striking when you read the legislation. It's been
2 sitting out there a long time. This didn't just happen.
3 And it specifically exempts ASCs. And I think the
4 issues were clearly that if a hospital -- the way these
5 are usually done, they are owned by physicians but not
6 to get the capital. There's generally a business
7 partner who makes a capital contribution and who manages
8 the facility and there are a number of these very
9 effective, highly ethical, very productive organizations
10 around the country that do this.

11 And what they'll do is go to a hospital or
12 community and identify a group of physicians who are
13 heavy
14 utilizers of these kinds of services. And say you guys
15 are doing this in your office, you're doing it in the
16 hospital outpatient, and the hospital doesn't have the
17 money to update its outpatient department and you've
18 been complaining for 10 years that the suite is archaic
19 and unsafe and it's more and more expensive for you to
20 do this in your office. And we'll give you the capital
21 if you guys come together as a group.

22 But of course, you realize that the patients

1 that are going to get treated here are the patients who
2 you treat. They're your patients. But we need you to
3 set up the clinical rules and the oversight and the
4 quality committee and the infectious control and all the
5 rest.

6 So because of that kind of built-in conflict,
7 these were exempted from the Stark anti-referral rules
8 because if they weren't ASC growth would have been
9 eliminated. And so that was the concern.

10 I served on the New York state committee that
11 oversaw the CONs or whatever for facilities. Remember
12 that, Carol. And this came up all the time.

13 And I would have to say my experience was that
14 the physician input was vital to the quality and to
15 running the thing in a clinically appropriate way. I
16 can't imagine how it could be done otherwise. So I know
17 it does give you the self-referral thing, but in fact,
18 they were referring these patients to themselves before.
19 In other words, they were doing it in their own office.
20 The patient would come and get a colonoscopy. That's
21 what they were doing.

22 MR. HACKBARTH: You've clearly explained the

1 historical rationale. Would you leave it that way?

2 DR. ROWE: Let's say I'm a gastroenterologist
3 and you sent a patient to me and the patient is pretty
4 sick and frail. And there's an ASC where I could do the
5 procedure or I could do it in my office. And I can't
6 send the patient to the ASC because I'm on the board, or
7 I'm an part-owner of the ASC, and all my partners are,
8 and all the gastroenterologists in town are.

9 So then I tell the referring doctor, Dr.
10 Nelson, I have to send your patient to Pittsburgh to get
11 a colonoscopy because all the doctors in town -- I mean
12 it's just stupid.

13 So sure, I'm sensitive to Nick's concern. And
14 we saw that with imaging centers. Doctors owned imaging
15 centers and patients would come in and then a lot of
16 people were getting CAT scans and there were questions
17 about whether or not the right clinical criteria were
18 being applied. I remember those bad old days.

19 But in this particular case, unless there's
20 evidence to the contrary, I think it seems to work.
21 Nick?

22 DR. WOLTER: I think you've explained well the

1 positive side of the story. I do think that in recent
2 years we're seeing an explosion of these. I'll tell you
3 in Billings we have about four of them now, or a fourth
4 one was just announced. I think, especially when
5 there's a high volume of single specialty ASCs, at least
6 the question of utilization should be raised.

7 I think that now that this has become a much
8 bigger movement and we're seeing a lot of dollars being
9 invested in duplicate infrastructure, and in fact, many
10 of these patients maybe come from what was previously in
11 the office but many are also coming out of what was
12 previously done in hospital outpatient. And I don't
13 know the sustainability of this over time, quite
14 frankly. It's become a major economic movement. And I
15 think there are pros and cons to this, and you've
16 outlined those well.

17 I do think we're going to need to monitor
18 this.

19 DR. REISCHAUER: Jack gave us the example of
20 some procedures that could be done in a physician's
21 office as well as an ASC or an outpatient. But there's
22 a lot of procedures that can't be done in a physician's

1 office and the choice is simply between hospital
2 outpatient and an ASC. And that's a different trade-
3 off.

4 DR. ROWE: Yes, that would be significantly
5 different and I view those differently.

6 MR. HACKBARTH: Jack, your description has
7 been helpful. What I'd like to do is learn more about
8 this and think about it some more. There will be other
9 opportunities, I think, to take up the self-referral on
10 a piece of this, either in a discussion of ASCs in
11 particular or maybe in some other context as well. So
12 let's hold off on that for now, Nick, if that's okay
13 with you, and focus on the three recommendations before
14 us.

15 Any other questions or comments?

16 Why don't you put up number one. All opposed
17 to recommendation number one? All in favor?
18 Abstentions?

19 Now help me out on number two. I know we had
20 some discussion about this. Are there any modifications
21 we want to make?

22 DR. MILLER: I think in response to Joe's

1 comment, the modification is in the second bullet point.
2 It would read something along the lines of the Congress
3 should require the Secretary to periodically collect ASC
4 cost data at the procedure level to monitor adequacy, et
5 cetera.

6 MR. WINTER: Can I suggest one other change
7 based on comments? To continue on from where Mark left
8 off, to monitor the adequacy of ASC rates, calibrate the
9 relative weights, or monitor the relative weights, and
10 develop a conversion factor that reflects the cost of
11 ASC services.

12 MR. HACKBARTH: We can tinker with the
13 language but I think the intent is pretty clear. Do
14 people understand what we're trying to get at?

15 So let's vote on number two with that
16 modification in mind. All opposed to number two? All
17 in favor? Abstentions?

18 Okay, number three. Any modifications on this
19 one based on the discussion?

20 MR. WINTER: One suggestion from David, I
21 believe, was to take out the third bullet and add a
22 sentence that says payment for services that are

1 routinely provided in physician offices should be no
2 higher than the physician practice expense office rate.

3 MS. DePARLE: I don't feel prepared to vote on
4 that today. I don't think I have any idea what the
5 implications of that might be.

6 MS. RAPHAEL: I was just going to suggest we
7 pull out the last one, payment differences, because
8 we're trying to do this in a clinically -- to me --
9 defined way having to do with safety and overnight stay.
10 And then all of a sudden we drop in there payment
11 differences.

12 So I just think that one has to come out for
13 this to make sense in terms of trying to figure out what
14 procedures should be approved or excluded. And then
15 whatever we do on this, I think we should do separately.

16 I was persuaded by what Ariel said that there
17 were some really compelling reasons not to go forth with
18 this because of payment implications.

19 MR. HACKBARTH: The proposal on the table is
20 to delete payment differences between ASCs and physician
21 offices.

22 MR. SMITH: That would accomplish, I think,

1 what Jack and I were trying to get at, that the
2 exclusion list here ought not to be based on a payment
3 consideration. And simply removing that would take care
4 of it and it would allow the clinically appropriate
5 decision to be made without having excluded the ASC
6 option on the basis of a payment difference. That would
7 accomplish what I think I wanted to do.

8 DR. REISCHAUER: But do we want the text to
9 reflect that this is an area of interest and further
10 analysis by us? Because I would think we would.

11 DR. ROWE: Also, really you can't have it the
12 way it's written because if you use the example I gave
13 of the pretty frail, multiply impaired, functionally
14 marginal patient then the clinical safety standard
15 indicates yes and the payment difference indicates no.
16 So then you have to have some mechanism to say well, if
17 one of these says yes and the other says no, how do you
18 determine which is subordinate to the other?

19 MR. HACKBARTH: I think that makes sense to
20 delete that third item and focus on the clinical
21 considerations in the note in the text that we'll come
22 back and think about the other issue.

1 With that modification, all opposed to
2 recommendation three? All into favor? Abstentions?

3 Okay.

4 MR. FEEZOR: Glen, just to underscore your
5 comment, the issue on Stark or other incentives or
6 disincentives, I'd like to put that as a potential issue
7 that we might plow into a little more somewhere offsite,
8 potentially.

9 MR. WINTER: Allen, we do plan to address this
10 issue as part of our study of specialty hospitals, which
11 is a Congressionally mandated study under the new
12 Medicare law. So we'll be looking at it in that context
13 and we can certainly think about it for the June
14 retreat, as well.

15 MS. DePARLE: But Glen, when we're looking at
16 it, and Allen and I had a chance to talk about this some
17 yesterday, we also want to make sure we're looking at it
18 in the context of the things that we're trying to do on
19 quality because we both think that until you allow
20 physicians' interest to be aligned with those of
21 hospitals and other providers that it will be hard to
22 achieve some of the things we're trying to achieve.

1 Even in the two areas where we made those
2 recommendations yesterday there are those issues. So
3 it's multifaceted.

4 MR. SMITH: Glen, on the same subject, as Nick
5 was raising his concerns a minute ago, I think there are
6 two issues here and they're not entirely covered by the
7 self-dealing, self-referral Stark provisions.

8 The other one is the cannibalization question
9 and whether or not that has an impact on the viability
10 of the hospital setting which needs to be viable for a
11 variety of other functions. Does the development of
12 this additional infrastructure have implications for the
13 architecture of the rest of the system that we ought to
14 pay attention to?

15 I don't have a view about the answer to that,
16 but I think that question is as important as the
17 potential conflict, self-dealing, kick-back questions.

18 MR. HACKBARTH: Mark was just saying that one
19 is a significant part, I think, of the specialty
20 hospital.

21 DR. STOWERS: [off microphone.] I don't know
22 if we need to get into service that requires an

1 overnight stay. We could just say based on clinical
2 safety. We've already voted on it, but I'm just saying
3 you don't need the bullets under it.

4 MR. HACKBARTH: All right, we're going to
5 change gears now for our last two agenda items: long-
6 term care hospitals and dual eligible beneficiaries.
7 These are both parts of the June report so we are out of
8 the process of voting on update recommendations for
9 March and looking a little further down the road.
10 Sally, whenever you're ready.

11 DR. KAPLAN: Good morning.

12 The purpose of this presentation is to bring
13 you the results from two qualitative studies of long-
14 term care hospitals.

15 As you know, qualitative research has
16 limitations. Results cannot be generalized because
17 samples are generally small and opportunistic rather
18 than randomly selected. In addition, informants
19 frequently are not objective. Nevertheless, when used
20 in conjunction with quantitative studies, qualitative
21 research provides context and color to enable
22 policymakers to have a better understanding of an area.

1 In the first study, NORC and Georgetown
2 conducted 34 interviews with physicians, hospital
3 administrators, nurses, and discharge planners in market
4 areas with and without long-term care hospitals.
5 Interviews focused on treatment and referral patterns of
6 patients requiring a high level of care for an extended
7 period of time. The principal investigators of that
8 study are in the audience if you have questions about
9 the interviews that I am unable to answer.

10 For second study Dr. Nick Wolter and MedPAC
11 staff visited three cities: Boston, Houston, and New
12 Orleans. Dr. Norbert Goldfield, a physician from 3M who
13 is very familiar with long-term hospitals, accompanied
14 us to Boston and Houston. Pete DeBusk accompanied us to
15 two long-term care hospitals in New Orleans. In all
16 physicians from 10 long-term care hospitals presented
17 profiles of patients in a grand rounds format, providing
18 information about each patient's condition, acute
19 hospital stay, admission to the long-term care hospital,
20 treatment, and discharge.

21 The results I'm presenting today address the
22 three research questions on the screen. These are three

1 of the five research questions we've consistently asked
2 in this study. These ask about the role of long-term
3 care hospitals, about how patients are treated in areas
4 without long-term care hospitals, and about outcomes.

5 Long-term care hospitals provide post-acute
6 care in to small number of stable, medically complex
7 patients. Many patients require ventilator little
8 support, have multisystem failure, neuromuscular damage,
9 contagious infections, or complex wounds needing
10 extended care. Long-term care hospitals extensively
11 screen patients. Representatives of these facilities
12 maintain that they select patients who have a prognosis
13 for improvement. They also screen for insurance and
14 reportedly generally do not admit patients without
15 insurance supplemental to Medicare. Medicare is by far
16 the biggest payer for long-term care hospitals. Some
17 long-term care hospitals have contracts with Medicaid,
18 some have contract with commercial insurance. Long-term
19 care hospitals have a feeder system of acute hospitals
20 that refer patients. Acute hospitals benefit from being
21 able to transfer patients to long-term care hospitals
22 and are a major driver for the growth in these

1 facilities.

2 Interestingly, on site visits, we were told
3 that physicians frequently are obstacles to transferring
4 patients to long-term care hospitals, either because
5 they do not understand the care long-term care hospitals
6 provide, or they may believe they have to turn over
7 their patients and lose control of their patient's care.
8 Families also can be obstacles if they did not
9 understand the difference between long-term care
10 hospitals and a long-term care facility or nursing home.

11 Patients in areas without long-term care
12 hospitals are treated in various settings. Some
13 patients stay longer in the acute hospital. They are
14 usually moved from the ICU or the CCU to medical or
15 surgical beds. Usually these patients would be high-
16 cost outlier cases.

17 Some acute hospitals have created units
18 stepped down from the ICU level of care and these units
19 treat patients similar to long-term care hospital
20 patients. Some SNFs are adequately equipped to handle
21 long-term care type patients. However, it is clear from
22 everything we were told in both studies that fewer of

1 these SNFs exist under the SNF PPS. I'll talk more
2 about SNFs in a moment.

3 On site visits inpatient rehabilitation
4 facilities were not mentioned as an alternative to long-
5 term care hospitals. However, NORC and Georgetown were
6 told that some IRFs do accept patients similar to those
7 treated in long-term care hospitals.

8 The biggest disagreement between what we were
9 told on site visits and in the structured interviews
10 concerned whether SNFs are capable of providing care for
11 patients treated in long-term care hospitals. On site
12 visits long-term care hospital representatives were
13 adamant that SNFs could not care for long-term care
14 hospital patients. They pointed to long-term care
15 hospital patients' need for daily active intervention by
16 physicians who are available seven days a week in long-
17 term care hospitals and not routinely involved in SNF
18 patient care. They also pointed to nurse staffing of
19 six to 10 hours per day compared with five hours per day
20 in hospital-based SNFs and three hours per day in
21 freestanding SNFs.

22 In addition, they told us that most long-term

1 care hospitals have physical, occupational, speech, and
2 respiratory therapists on staff and frequently employ
3 specialist RNs.

4 Regarding patients requiring ventilator
5 support long-term care hospital representatives told us
6 that only patients who were stable but with little
7 ability to be weaned were the type of patients SNFs
8 could treat. However, in the structured interviews NORC
9 and Georgetown were told that SNFs were the principal
10 alternative to long-term care hospitals. They were told
11 that some SNFs are adequately equipped to handle
12 ventilator-dependent patients or others requiring a high
13 level of care. These SNFs offer a level and intensity
14 of care that some respondents thought comparable to that
15 offered by long-term care hospitals.

16 NORC and Georgetown did more digging on this
17 issue. In one market at least three SNFs provide care
18 to ventilator-dependent patients. For example, one of
19 these SNFs specializes in respiratory care and over half
20 of its patients require ventilator support. Most of
21 these patients have other complications such as major
22 wounds, COPD, or multisystem failure. About one-third

1 of these ventilator-dependent patients are undergoing
2 active or semi-active attempts to wean them from the
3 ventilator.

4 This SNF has a pulmonologist medical director
5 who rounds with the nursing and respiratory staff.
6 There are two respiratory therapists onsite 24/7 and a
7 respiratory care director at the SNF every day. A
8 primary care physician makes rounds twice a week at this
9 SNF.

10 One thing everyone agreed about was that SNFs
11 capable of caring for costly patients are much less
12 common since the SNF PPS was implemented. As you know,
13 the SNF PPS overpays for rehabilitation patients but
14 respiratory therapy does not count towards rehab in
15 SNFs. It counts as an ancillary just like drugs and the
16 SNF PPS does not cover the cost of ancillaries
17 accurately.

18 NORC and Georgetown found mixed opinions about
19 long-term care hospital outcomes. Some respondents
20 reported that long-term care hospitals provided a
21 valuable service to patients who needed extended acute
22 care. Others told researchers that long-term care

1 hospitals could be overused when they admitted patients
2 with little chance of recovery. Still others reported
3 that long-term care hospitals postpone a timely
4 discussion of end-of-life issues.

5 In standard outcome measures long-term care
6 hospitals report wide variation on a hospital-to-
7 hospital basis. On site visits, we were told that 10 to
8 33 percent of patients die in the long-term care
9 hospitals and 35 to 90 percent of patients are weaned
10 from the ventilator.

11 Regarding patient satisfaction, patients and
12 families appear to appreciate the amenities at long-term
13 care hospitals. Frequently there are private lives
14 and/or rooms with windows.

15 As far as the next step in this research is
16 concerned at the March meeting we plan to present
17 results from two types of analyses, more multivariate
18 analyses and policy analysis. The policy analysis will
19 be designed to identify ways to better define long-term
20 care hospitals and the patients appropriate for them.

21 I'm happy to take your questions or comments.

22 DR. REISCHAUER: Thank you, Sally.

1 MR. DURENBERGER: This will just be a brief
2 comment without a question in it. As somebody who was
3 concerned about this in the beginning, I'm really very,
4 very impressed with the scope and the depth and the
5 variety of approaches that are being taken here. And
6 I'm totally impressed by the fact that Pete and Nick are
7 going to go out and be part of it, and obviously looking
8 forward to some of their reaction as you start moving
9 towards the policy design and so forth.

10 But this is just so impressive to see this
11 kind of a broad gauge support where we're not just
12 looking at it from the standpoint of this institution
13 with this name versus that one. But I sense that behind
14 that you're really looking at the issues of patient
15 care, and the family involvement, and the role of
16 professionals, and some of those other kinds of issues
17 which are really important for this particular
18 population.

19 DR. REISCHAUER: I think we'd all like to
20 associate ourselves with that comment.

21 MS. DePARLE: That's what I was going to say,
22 too. And I think you very well describe the limitations

1 of site visits and more anecdotal research. At the same
2 time I think it's vitally important that we get out of
3 our offices and see what's changing and how these
4 different providers are actually operating in the
5 marketplace and serving beneficiaries.

6 Nick and Pete, thank you on behalf of
7 everybody else for taking the time. I'll volunteer to
8 go out with you. I've been to I think one in
9 Philadelphia but it's been four or five years ago and I
10 think I could use some updating, too. I think it's
11 great work on the part of the staff.

12 DR. WOLTER: The one thing I would just say is
13 to agree with that. This is a complex topic. I did not
14 know much about LTCHs prior to these visits. And having
15 gone up the site visits but not been part of the
16 structured interviews, I was really impressed with how
17 you all put this information together. So an excellent
18 job.

19 MR. HACKBARTH: Any others?

20 Okay, thank you, Sally.

21 Last up is dual eligibles.

22 MS. MUTTI: This presentation introduces our

1 work plan and initial work on the dual eligible
2 population. And that's those beneficiaries that are
3 eligible for both Medicare and Medicaid coverage.

4 In addition to the briefing materials we sent
5 you in advance of this meeting, back November -- and I'm
6 not sure if you're going to remember this -- we did give
7 you a preview of our work plan. So you've had some
8 materials to get an idea of what our thoughts were on
9 this topic.

10 I just want to take a moment first to talk
11 about the reasons we felt that it was important to focus
12 on this population. First, as many of you probably have
13 noticed in numerous of our discussions on different
14 payment policies, questions have arisen about how dual
15 eligibles are paid for, what their care patterns look
16 like, what their coverage is. And we're hoping that
17 this agenda for work will answer many of those and
18 probably raise others.

19 Secondly, the very nature of this population
20 motivates us to put it on our agenda. These are a
21 vulnerable and costly group of beneficiaries. In terms
22 of vulnerability, by definition they are poor. They

1 tend to be more likely to be living alone, living in
2 nursing homes, be disabled, have more chronic
3 conditions.

4 In terms of costliness, they account for about
5 17 percent of Medicare beneficiaries but 24 percent of
6 spending. In terms of total costs, they are about twice
7 as costly as Medicare beneficiaries.

8 We also thought it was important because
9 there's been a variety of policy changes that have been
10 enacted in the last few years that may particularly
11 impact this population, be it PPS's for post-acute care
12 services, a prescription drug benefit, changes in how
13 Medicaid is supposed to pay for Medicare cost sharing.
14 All of these are important. And while we may not have
15 the resources right now to examine each of these
16 specifically, I think collectively we felt that they
17 warranted closer attention to this population.

18 Lastly, there's a number of other issues that
19 we're looking into, the implementation issues of the
20 prescription drug benefit, disease management proposals,
21 and both of those have implications for dual eligibles.
22 And certainly going over some of the basics of this

1 population, who they are, how they are paid for, what
2 their care patterns are, should help facilitate those
3 discussions, also.

4 The work plan us up on the screen. The first
5 two items, eligibility requirements and coverage and
6 payment policies, we will be talking about today and
7 we'll identify some of the issues that we've found so
8 far in our look at that.

9 In the future, we plan -- and this is
10 supposedly this spring -- we're going to be looking at
11 the demographic characteristics of this population.
12 We're particularly interested in teasing out the
13 subpopulations within duals because it can be a somewhat
14 diverse group. We'd like to look at their cost and use
15 of care and compare that to other beneficiaries, and
16 also look at access to care. And we're hoping to use
17 MCBS and CAHPS data, if not some other sources to
18 specifically look at responses by dual eligibles.

19 At this point, I'm going to turn it over to
20 Sarah, who's going to talk about eligibility
21 requirements and issues. then I'll come back and talk
22 about coverage and payment policy. And then we look

1 forward to getting your comments, both on the agenda and
2 the content of this presentation.

3 MS. LOWERY: About 90 percent of dual eligible
4 beneficiaries qualify to receive full Medicaid benefits
5 such as nursing homes or other institutional care, home
6 care, or dental care in addition to their Medicare
7 benefits. Beneficiaries can qualify for these benefits
8 either by also qualifying for Supplemental Security
9 Income, SSI, and meeting other asset requirements, or by
10 being medically needy.

11 A beneficiary is considered medically needy if
12 after deducting their medical expenses from their income
13 they meet a state-specified level. Medically needy
14 beneficiaries would not otherwise qualify for Medicaid
15 since their income and assets are above the
16 requirements, but they are essentially allowed to spend
17 down their income to qualify. And they're also often
18 called spend-down beneficiaries.

19 Medically needy beneficiaries often cycle into
20 and out of the Medicaid program since their eligibility
21 may change frequently. 39 states have medically needy
22 programs through which states have the option of paying

1 the Part B premium, in addition to providing full
2 Medicaid benefits.

3 On the other hand, states must pay the Part B
4 premium and cost-sharing for beneficiaries who qualify
5 through SSI, in addition to the full Medicaid benefits.

6 Additional programs, often called the Medicare
7 Savings Programs, created four other categories of dual
8 eligible beneficiaries. Qualified Medicare
9 beneficiaries, QMBs, specified low income beneficiaries,
10 SLMBs, qualifying individuals, QIs, and qualified
11 disabled and working individuals.

12 QMBs, which make up 6 percent of dual eligible
13 beneficiaries have incomes up to 100 percent of poverty
14 and a higher asset level than SSI recipients and states
15 pay their Part B premiums and cost-sharing.

16 3 percent of duals are SLMBs, who have incomes
17 between 100 and 120 percent of poverty with the same
18 asset requirements and states pay the Part B premiums.

19 QIs must have incomes between 120 and 135
20 percent of poverty, again the same asset requirements,
21 and states pay some or all of their Part B premiums.

22 DR. NELSON: [off microphone.] Is an owned

1 home excluded in the assets?

2 MS. LOWERY: Yes. Yes.

3 States pay Part A premiums for qualified
4 disabled and working individuals if they purchase Part A
5 after they return to work and have incomes less than 200
6 percent of poverty but don't qualify for any other
7 Medicaid assistance.

8 MS. DePARLE: Alan was asking me about the
9 assets test and you answered one of the questions, but
10 can you go back to that chart?

11 This may be too complicated, but how do the
12 assets test under these various categories compare with
13 what's in the DIMA for the subsidies for low income
14 people? Are the asset tests the same, or do you know?

15 DR. BERNSTEIN: [off microphone.] States have
16 different asset tests and some of those are similar to
17 DIMA and some of them are significantly lower. Some of
18 them are higher. They're all over the place.

19 MS. DePARLE: For DIMA it will be a nationwide
20 assets test. So the state may have its own asset test
21 for this purpose.

22 DR. BERNSTEIN: Right.

1 MS. DePARLE: And then also do the other one.

2 DR. BERNSTEIN: [off microphone.] They do set
3 floors for -- the state's program has floors. But for
4 full Medicaid benefits there are different assets tests
5 that vary by state.

6 DR. STOWERS: Another thing, usually Alan, if
7 they go into a long-term care facility, a nursing home
8 or whatever, then they only get to keep their home for
9 one year to be sure they're not going to get back out.
10 But at the end of the year, the house has to be sold.
11 And that asset goes into helping pay for their nursing
12 home care, in most states.

13 MS. LOWERY: Eligibility and benefits offered
14 to Medicare beneficiaries through Medicaid can vary
15 greatly by state, as you just talked about. For
16 example, states have the option to extend full Medicaid
17 benefits to beneficiaries with incomes up to 100 percent
18 of poverty. Some states do this and some do not.

19 Also, even if a beneficiary is eligible for
20 Medicaid benefits, they may not be enrolled in the
21 program because of various barriers to program
22 participation or they simply may choose not to enroll.

1 Outreach to beneficiaries, simply educating them about
2 the programs may not be effective and welfare workers,
3 Social Security employees, and community-based
4 organizations often don't have extensive knowledge about
5 the programs.

6 The enrollment process itself can be long and
7 complicated and often requires long waits in welfare
8 offices, face-to-face interviews, and extensive
9 documentation of income and assets that could deter
10 beneficiaries from enrolling, as well as difficulties
11 with language and transportation.

12 Beneficiaries may choose not to enroll if the
13 state has Medicaid state recovery requirements and
14 there's also a stigma associated with being on Medicaid
15 which may prevent beneficiaries from enrolling.

16 Enrollment in Medicaid and the Medicare
17 savings programs is often documented at significantly
18 less than 100 percent of eligibles. For example, only
19 about 16 percent of those eligible for the SLMB program
20 are enrolled and estimates of beneficiaries who qualify
21 for the QMB program range from 55 to 78 percent.

22 The differences that we have described in

1 eligibility and enrollment translate to differences in
2 health care benefits which can affect access to needed
3 care.

4 Now Anne will move on to coverage.

5 MS. MUTTI: By definition, dual beneficiaries
6 have both Medicare and Medicaid coverage but one of key
7 questions is which program covers which service.
8 Medicare is primary, and by that I mean it pays first
9 for the services that it covers in its benefit package.
10 While that may sound somewhat straightforward, it really
11 gets a lot more complicated because there's many
12 dimensions to coverage.

13

14 For example, for a Medicare service to be
15 covered it has to be provided by a Medicare approved
16 provider, it has to be deemed to be medically necessary,
17 it has to meet certain coverage criteria that certain
18 services have like a three-day hospital stay prior to a
19 SNF-covered benefit. Or the beneficiary has to be
20 homebound before being covered by the Medicare home
21 health benefit.

22 These examples raise the issue that there's a

1 lot of gray area, that we are guided by statute, and a
2 lot by judgment, too, on intermediaries, on their part.
3 And then if these decisions are appealed administrative
4 law judges can get involved and then their judgment
5 pertains here, also.

6 Medicaid is generally secondary. I just would
7 note that there are some dual beneficiaries who actually
8 have other sources of coverage and in that case they
9 would be secondary. But for the vast majority, Medicaid
10 is secondary.

11 It covers three types of health care costs.
12 Medicare cost-sharing, and I'm going to come back to
13 that in a moment because I will qualify that. Benefits
14 that have been exhausted under Medicare or are not
15 covered because of a certain characteristic is not met.
16 And that may be hospital stay, the episode has been
17 exhausted, or a SNF stay of 100 days in an episode has
18 been exhausted. And thirdly, benefits not covered by
19 Medicare, and this would include long-term care
20 services, most of those, as well as at the moment
21 outpatient prescription drugs. In 2006 Medicare will
22 have its own prescription drug benefit and at that point

1 Medicare will be primary on that. And certainly
2 implementation of that drug benefit raises a lot of
3 issues for dual eligibles. And actually my colleague,
4 fortunately, Joan, will be coming back to you to talk
5 through some of those with you.

6 But at this point I thought it might just be
7 useful to note that the benefit design of this
8 prescription drug benefit is really quite a departure
9 from other benefits in the Medicare package because it's
10 the first time -- that we know of anyway -- that the
11 generosity of the benefit varies by income of the
12 beneficiary. So that the cost-sharing requirements for
13 dual eligibles are quite a bit less than the cost-
14 sharing requirements for higher income beneficiaries.

15 We'd also note that coverage issues are
16 somewhat more complicated when duals are in M+C plans
17 because these plans have different benefit and cost-
18 sharing structures than under fee-for-service. These
19 plans, the cost sharing structure varies by plan and the
20 plans are increasingly charging premiums that are in
21 addition to the Part B premium. And this raises some
22 payment issues that I will come back to as we talk about

1 payment in M+C.

2 Turning to payment for beneficiaries who are
3 in fee-for-service Medicare. When a service is covered
4 by fee-for-service Medicare pays the provider the
5 Medicare payment rate, just as it would for any other
6 beneficiary. Historically, most Medicaid programs have
7 paid the Medicare co-insurance. But do to a
8 clarification in the BBA, the state program can opt to
9 pay a portion or none of that coinsurance if their
10 Medicaid rate is lower than the Medicare payment. In
11 other words, states are now required only to fill in the
12 Medicare cost-sharing up to their Medicaid payment rate.

13 So I'll give you a quick example. You've
14 probably heard this one before if you've gone through
15 this before.

16 If the Medicare total payment rate is \$100 and
17 Medicare pays 80 percent, we pay \$80. The remaining
18 coinsurance is \$20. If the Medicaid payment rate for
19 that service is \$90, Medicaid would pay \$10 of that
20 coinsurance to the Medicare provider. If the Medicaid
21 payment rate were \$70, and it was stated in their state
22 plan that they would only pay up to the Medicaid rate,

1 they would pay no coinsurance to the Medicare provider
2 for that service.

3 In general, beneficiaries cannot be charged
4 for this uncollected cost-sharing, but the impact of
5 this policy is that the providers will not get paid as
6 much for delivering that service to a dual beneficial
7 than most of its other patients that it may see,
8 assuming that they have supplemental coverage that pays
9 for this, and usually it does.

10 Facility-based providers, however, can offset
11 some of this loss because they can claim it as bad debt
12 and it is reimbursed by Medicare.

13 Somewhat different rules apply for outpatient
14 mental health services. I think I'll try using a
15 similar example. If the Medicare payment amount is
16 \$100, Medicare is only required to pay \$50, 50 percent
17 of that. Medicaid, at most, is required to pay only
18 12.5 percent or \$12.50 of that cost-sharing. The
19 beneficiary can be charged for the remaining \$37.50. So
20 there are some different rules for that type of service.

21

22 For beneficiaries enrolled in M+C plans,

1 Medicare pays a capitated rate to the health plan, just
2 as it would for any other beneficiary. However, because
3 dual beneficiaries are often sicker than other
4 beneficiaries, the risk adjustment formula produces a
5 higher payment for them.

6 For certain specialized plans, such as PACE
7 plans, the normal risk adjustment calculation is paired
8 with a frailty adjuster which pays plans a higher rate
9 assuming that most of their beneficiaries have
10 limitations in their activities of daily living.

11 Medicaid is the secondary payer and, in
12 theory, is responsible for the cost sharing. This
13 doesn't always happen. It's somewhat inconsistent, as
14 some case studies have shown. The issues that are cited
15 in this is often that the plans don't have information
16 that these beneficiaries are dually eligible. They do
17 not even know to go look for that money from Medicaid.
18 We've seen a number of studies point to the fact that
19 states have a hard time getting reliable and timely
20 information to plans.

21 M+C providers may also not be Medicaid
22 providers and therefore have a difficult time billing

1 Medicaid for the coinsurance. It's also possible that
2 Medicaid would claim that the M+C plan payment to the
3 provider was sufficient and exceeded the Medicaid rate
4 and therefore they do owe any additional cost-sharing,
5 similar to the fee-for-service provision.

6 In addition, I wanted to point out that
7 Medicaid is not required to pay Medicare plans premiums
8 and particularly as more plans are charging premiums
9 this ends up being perhaps a more significant issue.

10 Some states have opted to pay these premiums
11 because the additional coverage the premium buys, say
12 for example outpatient prescription drug coverage,
13 offsets what Medicaid would have had to spend otherwise
14 for this benefit. But in other cases, states do not pay
15 the premiums and beneficiaries are restricted in their
16 enrollment in M+C plans. Plans, if they do not receive
17 their premiums for three consecutive months, are
18 permitted to disenroll the beneficiary.

19 There are some innovative approaches out there
20 to integrating Medicare and Medicaid financing that
21 address many of these coordination of benefit issues,
22 and perhaps more importantly align incentives and

1 improve the quality of care that is delivered to this
2 population.

3 I won't go into detail on these programs now
4 but I just wanted to point them out and note that they
5 serve relatively a small portion of dual beneficiaries.
6 The thing that unifies these programs is that they
7 receive an integrated payment for Medicare and Medicaid
8 serves. Both are capitated payments for each program
9 services. They include PACE, which serves primarily a
10 frail elderly population, has a care model that is very
11 specific. It is a nationwide program but is currently
12 operating in about 14 states. Minnesota and Wisconsin
13 each have state waivers and have had several years of
14 experience now with integrating the payments and service
15 delivery there.

16 And then other states have launched other
17 programs that just capitate the Medicaid acute and long-
18 term care services and put particular emphasis on
19 coordinating with Medicare benefits. They may have
20 designated people who are designed to work with Medicare
21 providers to facilitate coordination of care.

22 Let me go on though to the issues and

1 implications that emerge from these coverage and payment
2 policies. First, we would note that spending for each
3 program is affected by the other program. And as a
4 result there is an incentive for cost shifting between
5 the two programs. For example, I talk about this a
6 little bit more in the paper, if a state Medicaid
7 program is successful in challenging Medicare denial of
8 home health claims, Medicare will pay those claims and
9 spend more money. This will relieve Medicaid from
10 paying those claims and they will save money.

11 This budgetary tension can also undermine
12 coordination of care. For example, Medicaid programs
13 may not invest in services such as care coordination
14 that reduces hospitalization because the payoff for that
15 investment is accrued to Medicare. They cover the
16 hospitalizations, they will get the savings.

17 Similarly, at a provider level nursing homes
18 have a financial incentive to hospitalized patients for
19 a three-day stay. So that upon discharge back to the
20 nursing home a Medicare SNF covered stay would be
21 triggered. Medicare payment rates are generally higher
22 than Medicaid and so the Medicare covered stay is

1 financially preferable. This incentive is tempered by
2 data that's being collected on rehospitalization rates
3 but nevertheless the financial incentive is in place.

4 These incentives for inefficiency and also the
5 bureaucratic wrangling over who pays for what service
6 likely increase total costs.

7 Then we just go to the impact of access and
8 note, just following up on our discussion before about
9 the limited cost-sharing provision that limit that
10 amount of payment, some providers may be less inclined
11 to take dual eligible beneficiaries. In fact, CMS did
12 contract for a study that looked into this question in
13 nine states and did find that there was a reduction in
14 utilization that correlated with a reduction in payment.
15 And this was particularly noted for outpatient mental
16 health services.

17 It is difficult to pinpoint the total impact
18 of this policy at this point. That study looked at nine
19 states. We don't know what's happening in all the
20 states. We don't know how much lower their Medicaid
21 payment rates are. And we don't know for what services
22 they've decided to this for because they can choose to

1 have different policies for different services.

2 Access to care could also be threatened on the
3 M+C side to the extent that beneficiaries are avoiding
4 care because they are being charged for it and they
5 actually shouldn't have been charged for it, and the
6 fact that Medicaid is not required to pay the premiums
7 may be a discouragement to these beneficiaries for
8 enrolling in this type of plan. That may be of concern
9 if you feel that this kind of plan would actually
10 benefit these beneficiaries who have a lot of health
11 care needs.

12 I would also note that recent legislation,
13 DIMA, did have a provision that allowed specialized
14 plans to focus on dual eligible populations, as well as
15 other vulnerable populations. And if they were focusing
16 on them they would be relieved of certain regulatory
17 requirements. And that may enable them to enroll more
18 dual beneficiaries. Of course, we don't know how that
19 will actually play out. And it does seem that it's
20 limited. It doesn't necessarily apply to those M+C
21 plans that are serving a much more diverse population
22 and haven't chosen to just focus on duals.

1 Lastly, we would note that there has been some
2 inconsistency in the way that conflicts between the two
3 programs rules have been resolved. For example, as
4 Medicaid programs begin mandating enrollment in managed
5 care plans, dual eligibles were exempted from this
6 requirement on the grounds that they were Medicare
7 beneficiaries first, and that as Medicare beneficiaries
8 they had freedom of choice. But as we see in the cost-
9 sharing provisions, that Medicaid payment is now
10 adequate for these beneficiaries. And in that case, it
11 seems that they're Medicaid beneficiaries first,
12 Medicare beneficiaries second.

13 I think with all those words, that concludes
14 our summary of payment and coverage.

15 I just would note what our next steps are. I
16 think we have a little bit more work to do on this area
17 and we look forward to getting your comments and out
18 some of the facts and implications. And then we want to
19 move on to the other areas that I mentioned before the
20 demographic characteristics, cost and use of care, and
21 access to care.

22 We're hoping to get this into shape for a June

1 report chapter. And we look forward to your comments on
2 the content and tone, and anything we might have missed
3 so far.

4 MR. DURENBERGER: I'll be brief.

5 I just want to thank you, Mr. Chairman, and
6 Mark, and obviously both of you for the quality of this
7 work. I think, as I listened to you go through this,
8 it's so much easier to understand than dealing with the
9 aggregates of all of the hospitals in America, and so
10 forth, because we're finally concentrating on looking at
11 this as people.

12 I laughed as you were going through the
13 presentation and I wish Sheila had been here, because
14 we're the people that are responsible for doing all this
15 sort of thing and creating all of these kinds of things,
16 which only reflects on the critical importance of
17 finding a way to undo it, is much harder. But we can't
18 do that unless we understand what it is. And that's why
19 the importance of this contribution to our work, I
20 think, is enormous.

21 I was looking at page 10 on the separate
22 payment systems and clearly this does not only apply to

1 low income dual eligibles. This applies to the whole
2 system, all of this, promotes cost shifting, undermines
3 coordination of care, increases total cost. This whole
4 list is the American health care system. So this is an
5 incredibly valuable insight, certainly for me and
6 hopefully for a lot of others.

7 One of the things that's a distinction here
8 maybe more than in other places though is the population
9 that's involved. And to that end, when you go back to
10 the beginning of the work product, I'd appreciate it
11 very much if we could spend a little time researching
12 the language that is used. And I put it under
13 information, education, communication.

14 Any of us who have ever been through the
15 system, either as providers or consumers, understand
16 nothing about the "benefit" or the enrollment. All of
17 this stuff is just totally confusing.

18 I really think, since we're going into this
19 new Republican world now with HSAs and MAs and all that
20 sort of stuff, and everybody's going to be walking
21 around with money to buy into the system, we really need
22 to focus on how do we communicate what it is that is the

1 most appropriate benefit, access, all these other
2 issues.

3 So to that end, and I know this maybe just be
4 another project rather than a project here, anyone who
5 is familiar with that part of the system knows that you
6 cannot put all of this into any kind of a one-pager or a
7 two-pager or anything else that will adequately present
8 a family faced with a particular situation or an
9 individual faced with a new crises with the kind of
10 information they need.

11 Just this little interchange here about is a
12 home deductible and all that sort of thing, I recall
13 going through this process with mother. She's just
14 living longer than anybody expected. But I got 11
15 languages to deal with, and that's only on the English
16 side. And then we move on to all of the other languages
17 in my community.

18 All of the information in the system,
19 including 1-800-Medicare, with on all due respect, is
20 unintelligible to the average American. And so if, in
21 fact, we are moving to getting the consumer, the family,
22 whatever it is, much more involved we really do need to

1 spend some amount of time helping the policymakers and
2 implementers focus on language and focus on what it is
3 we are trying to present them with in terms of
4 alternatives.

5 In addition to that, we have to get rid of
6 things like this is not a bill, and all the rest of
7 those things that confuse. But the most important part
8 is language and is communication.

9 And I would stress that in this population,
10 because across America -- and you know the data better
11 than I would -- but across America, including North
12 Dakota, Minnesota, Montana, places like that, the
13 cultural change in America in just the last 10 years is
14 enormous. And the way in which different people from
15 different backgrounds and different families are
16 confronted with the need to come into this system at the
17 level that we're talking about here, dual eligibles and
18 so forth, is enormous. And the way they think about it,
19 the way they react to information, the way they use that
20 information in a particular community, the way providers
21 have to react to that, is also an enormous challenge.

22 So I probably haven't put my finger on the

1 right phrase to use here, but in terms of what is the
2 work effort, if it is possible to put some time into at
3 least outlining the problem for policymakers, I think it
4 would be helpful.

5 MR. HACKBARTH: I think you're absolutely
6 right about how well or poorly we communicate these
7 things, although in this area in particular I think an
8 important part of the problem is that the underlying
9 policy isn't coherent. So you can spend forever trying
10 to state it clearly and make it sound better, but it's
11 hard to change the underlying reality.

12 MS. DePARLE: You just made my point. I
13 agree, Senator Durenberger, with everything you said
14 about communication. But whenever I return to the
15 subject, and you did a great job of outlining the issues
16 and the current state of the program, I'm reminded of
17 how crazy it is to have all these different categories,
18 QMB, SLMB, QI, DWI, QDWI, whatever it is.

19 What does that community to people except a
20 mess with all the different tests? Clearly what makes
21 most sense is if we had a separate thing that was
22 Medicare Plus or Medicare something for people who were

1 very low income.

2 I worry that the new DIMA provisions, while
3 well intentioned to help people who have the greatest
4 burden in trying to meet the costs of a new prescription
5 drug benefit, is only going to add to the complication.
6 I don't know whether that's anything that we could ever
7 have an effect on but certainly I think that's a big
8 part of the problem.

9 MR. DURENBERGER: You're making my point in so
10 does the Chairman. Our message has to be to
11 policymakers that -- because most of these people who
12 are here in this town understand nothing about the
13 policy that they're dealing with, in all reality.
14 There's a few people that understand the difference
15 between a QMB and a SLMB, but most of them don't
16 understand Medicare versus Medicaid.

17 So they have to be presented with the
18 challenge you faced as the administrator in a different
19 way, in a context which goes back to their district and
20 to the people that come into their offices and complain
21 about language and not understanding this and how come I
22 have to give up my home and things like that.

1 So I don't disagree that policy is the
2 problem. But I think we have to -- we should play a
3 role in putting a way to educate these policymakers on
4 the consequences and what are the alternatives. Thank
5 you very much.

6 MS. DePARLE: Yes, and the challenge that I
7 faced as the administrator was not this. I'm not proud
8 of that, but for every one call or letter I ever
9 received about any of these people, there were 500 about
10 which hospital fit into this or that category and wage
11 adjustment.

12 So we're not talking about -- I think the
13 point that Anne made at the beginning, is we're not
14 talking about 20 percent of our beneficiary population
15 who fall into this category. And whatever the reasons
16 have been before that we haven't focused on it, we have
17 to start focusing on them.

18 One thing that would help me, Anne, and I
19 don't want to add to your burden in trying to get this
20 done by June, but if there's a way to construct an
21 average -- there probably isn't, but an average dual
22 eligible to sort of give us a little more flavor for

1 here's what the person might look like. This is the
2 kind of spending they would have. They've been in a
3 nursing home in a given year or whatever.

4 Because we tend to look at things here in
5 stovepipes of services. This has come up repeatedly
6 over the last year, maybe those are duals. Is that who
7 that is, the high spending people in that category or
8 the ones where the nursing home is having trouble
9 covering them.

10 It would help me to see that. And maybe even
11 a low end and a high end. I don't know if that's
12 possible but I think that would help me to get a better
13 sense of who these people are.

14 MS. MUTTI: Absolutely. That was part of our
15 plan in our cost and user of services and also in our
16 demographic analysis, too. And maybe there's an average
17 dual beneficiary out there, but maybe there's not.
18 Maybe it would be helpful also to provide with you're
19 going to see there's three major types of dual
20 beneficiaries and their health care needs actually vary
21 quite a lot from each other. And this is what each of
22 those categories -- if we can do that, that's our goal

1 because I think it would help tease out what some of the
2 real issues here are, where the access problems are
3 going to be, who specifically would face those, if there
4 are any.

5 DR. WAKEFIELD: Some of the thoughts that I
6 had in reaction to this chapter have already been
7 expressed.

8 I'd say when I was reading it, the further I
9 got into the draft the more I started to reflect on,
10 there was some TV program that was something like good
11 pets gone bad. This is like a good program, God love
12 you for creating it, whatever role you had, gone bad.
13 That's just the sense I had.

14 The complexity here and the disservice and the
15 dissimilarities in a population that is, I think,
16 unarguably the most vulnerable of the population we care
17 about, really starts to come through here. I think most
18 of us would have recognized that in the back of our
19 minds. But you did an exceptional job of beginning to
20 tell the story. So that's my first comment.

21 And I'd say stay the course because this might
22 be one of places where we as MedPAC could make one of

1 our best contributions to the extent we can perform --
2 help first educate and then secondly inform people's
3 thinking about this in order to drive hopefully some
4 meaningful change over time. I can't think of a better
5 cause, personally, than really drilling down in this
6 area.

7 So you start to do that, at least you did it
8 for me when I was reading this. And I think it's a
9 really good use of our time and resources and so on. So
10 that's the first comment.

11 The second comment is I don't know that -- for
12 example, it was jarring reading about the mental health
13 coverage and that particular section as an example. I
14 don't know that you would ever have access to or we
15 could find anything that would tell us about whether or
16 not these people just sort of fall off in terms of being
17 able to access services. That is, we know utilization
18 drops but is there anything else that happens? Do we
19 see a bump up someplace else like in emergency room
20 visits or in hospital utilization when those benefits
21 start to slide down? I don't know that we've got data
22 that tells us that. What we know is that there's fewer

1 utilization, I think it was of inpatient mental health
2 services perhaps, or outpatient it was.

3 But is there anything else that's happening
4 that might have a cost implication for the program? Let
5 alone what may happen if we're assuming that this isn't
6 overutilization at the front end?

7 So if we got that, that might be a helpful
8 piece to toss in as well.

9 Two other comments. One, you do a nice job of
10 highlighting some of the state demo programs and the
11 PACE program. And you pretty much let the reader know
12 these things are not out there and they're having a
13 relatively small impact in terms of the total population
14 covered. I probably might even try and make that point
15 a little bit more firmly, because for example the PACE
16 program as it's currently constructed, it is extremely
17 hard -- although there are efforts being made -- to try
18 and reorient PACE so that it's viable in rural areas.
19 Historically, it has not been.

20 So when we start to look at the programs that
21 you're dishing up here as alternatives, they're great.
22 But A, to your point, I think the point needs to be made

1 strongly, not used very much. And in fact, there are
2 some real limitations in terms of where they can be
3 applied. So that's another point that I wouldn't lose
4 in all of this.

5 Your implications piece here, we're not teeing
6 this up at the level of recommendations at all when this
7 comes out in the June report. But I do think that to
8 the extent that we can put a road map out there in some
9 fashion, your implications start to move us that way, to
10 really say this is what's happening with coordination of
11 care, of quality implications and access implications.

12 I think, in addition to educating and
13 informing, without going to the level of saying here are
14 the 15 things obviously that need to be done, if we
15 can't go there, to be as clear as possible in helping
16 the reader understand what next steps might be at least
17 worth considering.

18 So as much effort as possible on the
19 implications side because the problem is so serious, the
20 challenge is so serious that if we can start help people
21 thinking about what might be some viable alternatives
22 and solutions without saying here are the 10 things that

1 must be done tomorrow, I think that's going to be well
2 worth spending some time, too. Not easy, but well worth
3 spending time. And you've started to do that with your
4 implication section.

5 So bottom line, really illuminating. I
6 thought the variability that you describe here is
7 jarring on the face of it within the program and I think
8 it's a great piece of work that you've kicked off.

9 MS. RAPHAEL: There were four points that I
10 just wanted to see emphasized as you move forward. The
11 first is that we actually have 50 Medicaid programs in
12 the United States not one. And I think that really
13 affects a lot of the other issues that we're trying to
14 wrestle with here.

15 Secondly, I think we need to really interlace
16 this with what we're doing on quality because I think at
17 the consumer level it really does affect quality. I
18 think that this particular group of beneficiaries,
19 because they have greater needs and utilize more
20 services, the fissures and cracks in the system are
21 magnified in their case. And when you look at
22 transitions, the failure to communicate information, the

1 need to move from one payment to another, I think really
2 is very, very important in terms of what happens on
3 quality.

4 I know in the long-term care system you could
5 prevent rehospitalization but there's no reward or
6 incentive to prevent rehospitalization. That's just one
7 example of many, many other examples of how incentives
8 are not aligned here at all.

9 A third issue for me, which you made and I
10 think I'd like to see some examples and really some more
11 emphasis, which is this adds to total cost in the
12 system. You mentioned the Medicare maximization
13 programs. I know we're just one of many, many
14 organizations where we've had groups, the state come in,
15 they want claims going back 11 years to rebill to
16 Medicare and say you have to hire 100 people to go and
17 really do the review of thousands upon thousands of
18 claims. And it adds a lot of costs to the system. And
19 there are many, many instances of one payer trying to
20 shift to the other payer and adding costs and ultimately
21 raising the price that the federal government is paying
22 overall.

1 Lastly, I would be very interested in seeing
2 if you could pull together something more on managed
3 care because ostensibly this is the group for whom you
4 would want some managed care options. This is a group
5 that really could benefit, whether we call it
6 coordination or managed care, care management.

7 So I'd like to kind of see right now what is
8 the state of what's happened in managed care, whether
9 it's in M+C or in one of these integrated managed care
10 programs or moving to disease management or chronic care
11 management. And some notion of what we think might be
12 possible in terms of trying to have some real viable
13 managed care options here.

14 And is it risk-adjustment issues or is it the
15 lack of real clinical models that's impeding work? Or
16 is it ultimately the financing? Because I don't think
17 we're yet laying the groundwork for the next generation
18 of managed care for this particular population.

19 DR. MILLER: Can I say just one quick thing on
20 your very last point? This is one of the groups that
21 we're going to be talking about in our disease
22 management analysis. So I think some of what you said

1 on your last point could also be dealt with there. But
2 wherever it falls, it falls.

3 DR. REISCHAUER: Anne and Sarah, I think
4 you've done a really good job and we've started down the
5 right path here. I've groveled around in this
6 literature a good deal over the last few decades and I
7 learned quit a bit from this.

8 I initially was being motivated to speak
9 because I wanted to disagree with Nancy Ann when she
10 mentioned the word average. And then Carol came in and
11 said what I was going to say on that score.

12 I think averages here are dangerous. In fact,
13 they might describe something that doesn't exist both
14 because, as you pointed out, there are different in a
15 sense flavors of Medicaid beneficiaries, full duals,
16 QMBs, SLMBs, et cetera. But also because the state
17 programs vary so tremendously.

18

19 The ramifications thereof are less for the
20 elderly than they are for the non-elderly population.
21 But nevertheless they are significant. And I was hoping
22 what you could do is pick a couple of very different

1 state programs. I think there are some programs that
2 pay quite high to providers and some that pay abysmally
3 low and some that have very rigid eligibility standards
4 or enforce the federal ones, and some that are a little
5 looser and goosier about that. And just sort of give us
6 a flavor for that, rather than the average.

7 The other thing I was wondering whether it
8 would be possible in the demographic analysis to give a
9 picture for the fully dual eligibles of when and how
10 they come on and how long the stay. I have no idea
11 whether of the fully duals, 80 percent of them come on
12 when they first get Social Security full eligibility at
13 age 65 and stay on until they die, unlike the working
14 population and the Medicaid people. Or whether a very
15 high fraction of them sort of come on as their incomes
16 go down. It's the 75-year-old widow who doesn't get the
17 pension anymore from her spouse who's passed away and
18 whether we're dealing with that sort of person.

19 If it's the former it really strikes you as
20 crazy that we do this the way we do it because we have
21 these people, in a sense, in our responsibility for a 20
22 or 30 year period. So to have them handled the way

1 they're being handled makes no sense.

2 DR. ROWE: Another category are the ones who
3 are in long-term care facilities and become Medicaid
4 beneficiaries because of the spend-down of their
5 resources. And that is a particular subset that might
6 be particularly interesting to look at with respect to
7 their utilization.

8 DR. STOWERS: I also thought it was a great
9 chapter.

10 I wanted to get back a little bit talking
11 access and quality to that copayment issue that you had.
12 I know in my practice our state makes a very strict
13 point to keep below the 80 percent of Medicare payment
14 levels. And I think that's the case in a lot of the
15 states, so physicians are taking care of these
16 individuals at essentially the Medicare rate without the
17 copayment. So that gets to be a problem with access and
18 I think we need to look at access in that group like
19 you're talking.

20 But in my personal observation the real access
21 problem here becomes in the ones we just talked about in
22 long-term care facilities where the Medicare payment for

1 taking care of nursing home and long-term care patients
2 is extremely low anyway for physicians. And then we
3 turn around and reduce that payment by another 20
4 percent. And the number of dual eligibles in our
5 nursing home, we may want to bring up also, is a very
6 large percentage of those patients.

7 So the majority of the nursing home patients
8 end up getting taken care of for a very discounted rate.
9 And therefore, it's very difficult to find physicians
10 that will get into this kind of care and take care of
11 these people where real coordination of care that was
12 mentioned before is really needed. That goes for home
13 health or anything else where we're trying to take care
14 of those individuals.

15 So I think that would good in this to get the
16 data somewhere along, and you may already have it, of
17 comparing the Medicare payment rate in the states to
18 what the Medicaid payment rate is. And therefore we can
19 really see what physicians are being paid. Are they
20 getting a copay? Are they not getting the copay by
21 state? And maybe that will answer some of our access
22 problems.

1 But anyway, good chapter.

2 MS. MUTTI: We don't have that data right now.
3 We'll look for it and see how we do.

4 MR. SMITH: Thank you. This was terrific
5 stuff and almost everything that my colleagues have said
6 I agree with. Let me just try to quickly underscore
7 three points.

8 I thought Dave Durenberger's initial reaction
9 was exactly on target, that this chapter ought to cause
10 those of us who have some responsibility for all of this
11 to say oh my God. As we think about what this chapter's
12 purpose is, we ought to see it in the context of a
13 motivational instrument rather than a technically
14 accurate and descriptive one. That's tricky business
15 for us, but I think Dave and Nancy Ann had that exactly
16 right.

17 Some of the questions that Bob raises about
18 the demographics of these folks, there are two sets of
19 questions. The take up rates here are low. And is
20 there something important to understand about who
21 accesses this loony movie system and what sort of
22 utilization they are able to therefore make of the

1 health care apparatus. And the slightly larger number
2 of folks, it seems to me, who are eligible but don't
3 access it, and what do their utilization patterns look
4 like.

5 And related to that, and it's a question that
6 grows out of Carol's observation and a little bit of the
7 work you've already done on the specialized programs, is
8 there anything, whether it's state Medicaid payment
9 rates or access to one of the specialized programs, PACE
10 or Wisconsin or Minnesota, is there anything that we can
11 look at and say this is associated with higher and more
12 appropriate utilization? That might begin to pave some
13 of what a road map might look at. The kind of road map
14 that Nancy Ann talked about.

15 The answer may well be no, but as we look at
16 variations in utilization, it might be useful to ask
17 ourselves are there any characteristics here which seem
18 to be systematically associated with better utilization,
19 no matter how complex the apparatus is.

20 MR. HACKBARTH: Okay, well done. Thank you.

21 We'll now have a brief public comment period.

22 MS. SMITH: I'm Alyse Smith with the American

1 Health Care Association representing skilled nursing
2 facilities.

3 First of all, I just wanted to express my
4 deepest appreciation for this work that is going to be
5 done on the dual eligibles because, as we have said so
6 very often, because of the great percentage of dual
7 eligibles in nursing homes this truly affects and
8 impacts our ability to provide care.

9 I just want to mention one thing, and we will
10 supply the MedPAC staff with this information. All
11 across the scene it is as if the left hand does not know
12 what the right hand is doing when it comes to the
13 particulars of some of these programs. For instance,
14 MedPAC staff said that unpaid copayments are covered by
15 Medicare as allowable bad debt.

16 What has happened at the end of last year is
17 that the Centers for Medicare and Medicaid Services
18 issued a proposed rule proposing a reduction in bad debt
19 allowance of 10 percent in the first year, 10 percent in
20 the second year, 30 percent in the third year, and hen
21 forever after 30 percent to equalize it, so to speak,
22 with the 30 percent on the hospital side that was put in

1 place by statute.

2 There was no mention in the proposal rule of
3 dual eligibles. The word Medicaid never surfaced.
4 There was no mention of the percentage of dual eligibles
5 in nursing homes, the percentage of Medicaid patients in
6 nursing homes, and the potential percentage of very high
7 bad debt attributed to unpaid copayments regarding
8 Medicaid patients.

9 We supplied all of this information to CMS and
10 to their credit, at least to this point, the final rule
11 has been delayed and delayed because I think it is being
12 further scrutinized. I simply raise this because all of
13 these pieces are out there and few people have tried to
14 put them all together in one place.

15 Thank you very much.

16 MR. CALMAN: I'm Ed Calman. In General
17 Counsel to the National Association of Long-term Care
18 Hospitals. I have one observation and two comments.

19 The observation is I really want to tell you
20 what a fine job your staff is doing in their long-term
21 care hospital study. I've been around for awhile. This
22 study is being done with more than ample resources,

1 appropriate resources, an open mind, and a sincere
2 dedication to getting the right answers. I think you
3 ought to be very proud of them and how they are
4 proceeding.

5 My two comments are as follows: in the
6 discussion of long-term care hospitals in the public
7 materials there's the statement that long-term care
8 hospitals provide post-acute care services to a number
9 of stable medically complex patients. Patients who are
10 admitted to long-term care hospitals are not necessarily
11 stable. Long-term care hospitals have most of the
12 resources of other hospitals. Patients in long-term
13 care hospitals, they have codes. They have management
14 of medically complex cases that are unstable. The
15 objective is that they become stable so that the wound
16 and the weaning in the same patient can occur.

17 That's my only comment with respect to the
18 findings that were made today.

19 I'm impressed and interested in the discussion
20 of dually eligibles because long-term care hospitals
21 have a stake with dually eligibles. I sit at my desk
22 and I get phone calls from various states. The one

1 that's the worst is Alabama, where there's only five
2 Medicaid days allowed per year. So a dually eligible
3 that's a long stay in a long-term care hospital, and we
4 have them, ends up with zero Medicaid coverage,
5 especially in the states of Alabama, Mississippi, and
6 Texas. It's very unfortunate because the incentive is
7 to drastically underserve these patients.

8 And I'm familiar with Alabama, all of these
9 patients or most of them end up in one state hospital
10 that's run by the University of Southern Alabama. And
11 then they bounce from nursing homes to hospitals. If a
12 study was done on their morbidity, I think they would be
13 true victims of this Medicaid eligibility system.

14 When we had the Catastrophic Coverage Act of
15 1988, the one thing it did that was not controversial
16 was do away with the Medicaid day limit. And it did not
17 cost much. I remember I was looking at the CBO cost of
18 that, it was scored separately. And that brought a
19 uniform standard of care to all these patients across
20 the nation for hospital care. And it was a real shame
21 that it was repealed because that was a great leap
22 backwards for these cases. And if a study was done, I

1 would assume that morbidity went up because of that
2 action by Congress.

3 At any rate, thank you very much for your
4 inquiry into these areas.

5 MR. FENNIGER: Randy Fenniger, Federated
6 Ambulatory Surgery Association. I have what I trust
7 will be very brief comments on the recommendations that
8 have been considered and voted on.

9 First, on payment advocacy, we've expressed
10 this before and continue to be concerned that since
11 there is no data, the Commission falls back on the use
12 of proxies which we think are not an accurate reflection
13 of whether reimbursement for a given set of procedures
14 is adequate or not.

15 You're looking at an ASC system that has
16 evolved into what it is in terms of Medicare, not what
17 it might be. There are some 2300 covered procedures,
18 many of which are not done with any great number in the
19 ASC. I would wonder are those rates, in fact, adequate,
20 inadequate, why are they not being done in the
21 ambulatory surgery center when they are being done in
22 the hospital outpatient department?

1 So I think that the lack of data is a
2 handicap. We urge a great deal of caution in your
3 evaluation of how well we are or are not doing based on
4 the proxies that you've established to date.

5 I would only make an observation here, in
6 dealing with urologists, who have started to move into
7 the ambulatory surgery center arena in small numbers,
8 not compared to ophthalmology or GI. The primary reason
9 is not the rates. They all complain about the rates at
10 the ASC level. It is the efficiency of the model. They
11 can do twice as much work in the ASC as they can in any
12 hospital in America. And so it is a quality of life, it
13 is an efficiency of practice that motivates them.

14 And I think as you consider adequacy of rates
15 and some of the other issues that came up in discussion,
16 you have to look at all of the motivations for the
17 development of these centers.

18 Your second recommendation, which you voted
19 on, I do not understand the discussion around capping
20 the ASC rate at the HOPD rate whether or not it's
21 determined the ASC cost is higher than the HOPD rate.
22 if it is higher, pay it. If it's not, pay it at the

1 rate at the cost that it exists. But to simply say this
2 is the cap, you've got to live with it no matter what we
3 learn, seems to me a rather arbitrary decision to make,
4 inconsistent with the idea that was expressed in part of
5 the discussion that what we want to do is try to figure
6 out what the costs are and then make sure we pay our
7 fair share of those costs.

8 So I would encourage you to move away from
9 that kind of arbitrary cap idea and deal with the
10 numbers as the numbers ultimately come out, if they ever
11 do come out.

12 The collection of data to constantly or
13 continually evaluate and update a new payment system,
14 the existing payment system, any payment system, is
15 theoretically a wonderful and necessary idea. In the
16 ASC industry history works against us. Unfortunately,
17 the Department has a very poor track record, as has been
18 discussed here many times, in the collection of data
19 about ASC costs and activities.

20 We're very concerned that if your
21 recommendation goes forward and, in fact, gets
22 incorporated in whatever new payment system comes out,

1 that we will be again held hostage to the unwillingness
2 and/or inability of the Department to collect this
3 information.

4 I don't have an answer to that but I hope that
5 you will consider this very carefully as you go forward
6 because part of the reason that these issues have been
7 brought to your attention has been problems with data
8 collection and updating the system in the past. Please
9 don't put it in that box again by another
10 recommendation. We would welcome your advice to not
11 only us but to the Department of how to get around this
12 problem so we don't relive this particular situation.

13 Recommendation number three, the comment on
14 the development essentially of a new coverage process
15 for ASC procedures being done either simultaneously or
16 after the completion of the payment system, I would
17 argue strongly there is no reason the Department could
18 not work on the development of new coverage standards.
19 They have done some work going back to '98 which was
20 published, never adopted.

21 I can certainly understand not introducing
22 that until you've introduced a new payment system. That

1 would be chaotic. But we think that it makes very
2 little sense to introduce a payment system and not at
3 the same time come in with new coverage rules. So we
4 would ask that you consider that aspect of that timing
5 so that both come out at the same time.

6 Again, being very concerned that if they issue
7 the payment system, they haven't looked at the coverage
8 rules, my grandchildren will have grandchildren by the
9 time we see new coverage rules, just based on history.

10 You dropped the issue of the physician office.
11 We thank you for that. I would only note that the
12 practice expense portion of the physician payment is
13 calculated differently than all other costs in the HOPD
14 or the ASC. You're going to have to grapple with that
15 issue when you come back to it.

16 I would also note that anything a doctor does
17 in his or her office they can do in the outpatient
18 department of the hospital. There's no limitation. Why
19 would you put an arbitrary limitation on their going to
20 the ASC with they can go to the HOPD. I just don't
21 understand that.

22 Deja vu all over again, self-referral. Just a

1 few comments if I may, without trying to grind my teeth
2 because I've been through this so many times.

3 When Stark was debated, the specific issue of
4 the ASC ownership was debated. They were dropped from
5 the legislative consideration, the reason being the ASC
6 was seen as the extension of the practice. The
7 physician refers and then goes to perform the service
8 himself or herself, a vastly different scenario than
9 referring to a laboratory radiology center in which you
10 have ownership interest, benefit from the referral, but
11 do no work yourself. I think that distinction holds.
12 We would certainly argue that in a 30 year history of
13 ASCs there's no evidence of overutilization.

14 I do know that when the Florida people, back
15 in the early '80s, looked at these issues, they did
16 examine ASCs in Florida, found no problem worthy of
17 raising, although they did find problems in laboratory
18 and radiology which ultimately became the basis of much
19 of the legislative consideration.

20 Interestingly, the safe harbor for ASCs
21 requires owners to do a certain amount of their practice
22 in the ASC, thus forcing volume into the ASC if you were

1 an investor. So one part of the law is saying you've
2 got to do it there. And so when you think of self-
3 referral issues, you have to keep that in mind.

4 I am struck by the issue of conflict of
5 ownership of an ASC by a physician. I don't see that
6 that is any different, if there is a conflict at all,
7 than ownership of a physician by a hospital. If we
8 can't own things, they shouldn't be able to own people
9 because they own practices and employ physicians. And I
10 think if there is a potential for conflict and abuse, it
11 can exist in any of those settings. Frankly, I don't
12 think it does exist, but I think the potential is there
13 and they should be evaluated equally.

14 Finally, the movement from the hospital, which
15 I know you will be talking about in other guises, I
16 would give you one anecdotal situation. Why do
17 procedures move out of hospitals and into other
18 settings?

19 Empire Blue Cross-Blue Shield, some of you,
20 perhaps Dr. Rowe is very familiar with them as an
21 insurance company, sent a letter to gastroenterologists
22 in their coverage area who practice at hospitals, mostly

1 teaching hospitals in New York and Long Island, saying
2 we're dropping you from our plan. Why? You do too many
3 endoscopies in the hospital. So go do them somewhere
4 else if you want to stay in our plan. Do them in your
5 office or do them in an ASC. A particular hammer on a
6 teaching institution.

7 But here you had a private insurance company,
8 the largest private carrier in the New York metro area,
9 saying we want you out of the hospital. We won't pay
10 you. We won't send you patients. We won't pay our
11 enrollees if they see you.

12 So there are a lot of things going on to move
13 things out of the hospital and into other settings other
14 than perhaps income aspirations of some owners or
15 investors. I'd simply ask you to keep that in mind and
16 investigate that very carefully as you move into this,
17 not only with the ASCs but the specialty hospitals. And
18 I'll be back for that one, too.

19 Thank you.

20 MR. MAY: Don May from the American Hospital
21 Association. I just want to make a couple brief
22 comments.

1 I really appreciate all of the discussion that
2 you had here today. The insights and perspectives that
3 you all bring to the various subjects are very
4 enlightening and helpful to us to hear all the different
5 perspective.

6 Two things. One is on the dual eligible
7 discussion. It becomes pretty obvious that our health
8 care system, if you want to call it a system, is pretty
9 broken. It's broken at how we provide care and how we
10 pay for care. And it really raises some fundamental
11 questions about how do we change how we do this versus
12 tweaking it and all the little pieces that we do on an
13 annual basis in all the different programs we have.

14 But I guess we do have to tweak. And so for
15 the tweaks, let me just raise my second point on the
16 outpatient outliers issue. We definitely agree that
17 there's a problem in how outliers are currently paid in
18 the outpatient system. And I think the real problem
19 here is not that outliers aren't necessary in the
20 outpatient PPS, but that the unit at which they're paid
21 is too small, which frustrates us all when an x-ray
22 seems to be the most reimbursed item in the outpatient

1 PPS outlier system.

2 I would offer two thoughts there. One is we
3 definitely need to increase the bundle and look at how
4 we pay the outliers.

5 The second thing is I think it's based on the
6 fundamental flaw of the outpatient system that it's
7 underfunded. You've set an average payment for
8 outpatient and an averaging system where the average
9 payment is well below the average cost and it makes it
10 very difficult for an averaging system to work when that
11 average payment is set well below the average cost of
12 care.

13 We were somewhat concerned today when we
14 didn't see some of the other options that were discussed
15 last month around raising a threshold, at looking at
16 expanding a bundle. And I think that had some different
17 analysis been done to show if you change how you pay
18 outliers, it may have driven some results that may have
19 been more in line with what I think people were
20 frustrated that they didn't see, that outliers were
21 going to the most expensive cases. Which is really what
22 we care about, is covering the most costly cases, either

1 the new procedures that are first moving out of the
2 inpatient setting into the outpatient setting, or that
3 happens to be the train wreck case that really does cost
4 an exorbitant amount of resources.

5 We still believe that they are very important,
6 especially since the outpatient system is still very
7 volatile with changes in payments from year-to-year at
8 the APC level, and in particular losing the transitional
9 corridor payments that go away beginning this January.
10 The extra protections that were in those payments are
11 now gone for the hospitals who are doing some of the
12 most costly procedures. And we really do believe that
13 those are necessary.

14 Thanks again.

15 MR. HACKBARTH: Okay, we are adjourned. Thank
16 you.

17 [Whereupon, at 12:07 p.m., the meeting was
18 adjourned.]

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