MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Wednesday, January 16, 2002
9:34 a.m.*

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
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JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

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P R O C E E D I N G S

MR. HACKBARTH: We're going to start out with a welcome to our guests. Julian, the floor is yours whenever you're ready.

MR. PETTINGILL: Good morning. Thank you.

We begin this morning with an effort to consider generically a question that you will face in various forms throughout today and tomorrow as you discuss payment policy recommendations for the March report.

The issue is whether and how Medicare should consider and account for factors that are not related to providers' costs of serving Medicare beneficiaries. Examples of this kind of factor include extra payments for Medicare's share of providers' uncompensated care costs, resolving geographic disparities in Medicare+Choice payment rates, and situations in which other payers' payment rates are substantially higher or lower than their costs of serving the payers' patients.

We sent you a short paper to stimulate your discussion on these issues and try to determine how you want to deal with them. No immediate action is required. There's no recommendation on this in the March report. But

we thought it important to get you to consider this question at the beginning because it might influence your thinking as these factors pop up one at a time throughout the day.

The first question is what makes these factors policy relevant? Well, as noted, they are largely or totally unrelated to providers' Medicare costs. They generally reflect other objectives beyond maintaining simple access to care for beneficiaries in each market. And policymakers and advocates have frequently pursued them through adjustments to Medicare's payment rates.

More fundamentally, they all entail tradeoffs in some form or other, spending more Medicare money than we otherwise would perhaps, or spending more for one thing and less for another. As indicated in the paper, these factors raise questions at multiple levels. Are the underlying objectives worthy? If so, are they appropriate for Medicare spending? And if that's true, then should they be accomplished through the payment rates or by some other means?

We have to answer questions about worthiness of the objectives and whether they're appropriate for Medicare spending case by case. Once those are resolved, however,

MedPAC's payment policy framework sheds some light on the question of what are the consequences perhaps of modifying Medicare's payment rates. The framework basically starts from the proposition that Medicare's payment system should support Medicare's overall objectives. That is, ensuring beneficiaries' access to high quality care without imposing unwarranted burdens on either beneficiaries or taxpayers. And to do that, the framework suggests that Medicare's payment rates have to be at least equal to a provider's short-run marginal costs or they won't offer services. But in addition to that, the provider's avenue revenues from all payers have to be at least equal to their average costs in the long run or they retreat from the marketplace.

The framework further points out the discrepancies between the payment rates, Medicare's payment rates, and marginal costs create financial incentives that may cause problems for either beneficiaries or taxpayers or both. Consequently, because pursuing other objectives through Medicare's payment rates creates just such payment discrepancies, we would expect these objectives or these policies may create a situation in which in solving one problem we create other problems.

That doesn't mean that we can't, or policymakers can't, address other objectives through Medicare's payment systems by altering the rates, but that they may well incur some costs if they do so in the form of greater Medicare spending or effects on providers' behavior from payment rates that are either too high or too low. These kinds of effects would be too much care, too little care, or maldistribution of care among types of services or markets.

Effects on the payment rates are often not small, as we pointed out in the paper. The example we gave you was the subsidy portion of the IME and the DSH, which together often represent a payment rate increase on the order of 30 to 40 percent, and sometimes quite a bit more than that. Whether and how much that distorts providers' behavior is less clear. We can't tell that from the example.

It's also important to ask whether these policies work. Are the objectives being pursued accomplished? The first problem sometimes is we aren't sure what the objective is, so it's a little hard to tell whether it's being accomplished. The example I gave there was the subsidy portion of the IME, where it isn't clear what we're buying.

But second, even if we know the objective, payment

adjustments are frequently unlikely to work well unless they're tied pretty closely to the desired behavior. A good example of that is the subsidy payments for DSH for uncompensated care, where the measure we use departs a great deal from the uncompensated care we're trying to support. So it's unclear whether we're encouraging hospitals to provide the uncompensated care we seek.

Third, even if the policies work, the costs in higher Medicare spending and undesirable effects on providers' behavior may exceed the benefits.

Finally, the same objectives might be accomplished more effectively at a lower cost by some other method. One could certainly conceive of a way of supporting uncompensated care for non-Medicare beneficiaries that would give providers direct incentives to provide that care, for example.

The paper finally offered some potential conclusions. These conclusions are highly tentative.

MedPAC's payment policy frameworks suggests pretty strongly that Medicare's payment systems can't be used to pursue other objectives without incurring potentially important costs. Therefore, we should avoid using the

payment systems to pursue other objectives unless there is no other way to get there.

We should also be skeptical that there is no other way. And even if that claim turns out to be true, you still have the problem of trying to balance the benefits against the costs.

The last bit we provided in the paper was the question of where you want to go here. Well, of course, our purpose was to get you to talk about these issues and what you do with them is yet to be determined. I gave you three options here that are not mutually exclusive. You could do any one of them or all of them. Simply discuss them today and try to use your discussion as you go through the issues later today and tomorrow to try to be consistent, as Glen mentioned earlier, agree to pursue some of these issues further next year such as DSH or the subsidy portion of IME, but also possibly think about the implications for broader issues such as Medicare reform or reform of the benefit package, which you will be discussing as we discuss the June report later this year.

That's all I have.

MR. HACKBARTH: Before we start the discussion let

me just provide a little context for our guests. As most of you know, our primary objective for today and tomorrow is to finalize recommendations for our March report, which primarily is about the update factors for the various provider groups within the Medicare program.

We're starting with two pieces this morning, including the one that Julian just presented, that deal with some more abstract, more conceptual issues that we think will be interwoven through the discussion of the more specific update topics. So that's why we're beginning with this presentation that maybe isn't what you expected to hear first thing this morning.

Comments from the commissioners or questions for Julian?

DR. NEWHOUSE: First, Julian, let me compliment you on the chapter. I think it fills a need. My reading list says I don't think there's any good description of the prospective payment systems, so I'll have to change that now and put this in its stead.

Before I come to the questions you posed at the end on where to go from here, at several points in the draft you bring up issues with the various systems. There were

several issues -- one could go on and on and fill the whole report, I think, with just issues. But there were three, I thought, that ought to be added.

One was the issue of substitution across settings for the same service when one is paying different rates. One harks back to the rural report and we talk about larger numbers of DRGs or at least the number of DRGs.

You mentioned the need to monitor -- at least this is the way I read it -- monitor what was going on and what was the appropriate intensity in rehab. But I thought that issue certainly could come up in the home health discussion and potentially in SNF, as well.

On the question you really wanted us to focus on, which is where to from here, my reaction was is this something the Congress is looking for? Are they receptive to hearing our opinion on this?

MR. HACKBARTH: There are two separate things here. There is, in our notebooks, the draft chapter which will be included in the March report, which is a truly excellent overview of the various payment systems. What Julian just presented via overhead is separate from that. This is not to be included in the March report but really

came out of our discussions at our last meeting.

Let me be a little bit more concrete about it. One of the specific issues that came up at the December meeting was what is the relevance of total margins -- Medicare, non-Medicare -- in making decisions about Medicare payment rates? For example, should we consider the fact that urban hospitals have lower total margins than rural hospitals in making decisions about the appropriate update factors or adjustments in Medicare inpatient payment policy?

Should we consider the fact, using another example, that free-standing skilled nursing facilities have very low, in many cases negative, total margins because of Medicaid payment policy? Is that relevant for our decisions about how Medicare pays skilled nursing facilities?

So Julian is trying to take that sort of issue and look at it a little bit more broadly and raise some of the implications of looking beyond the relationship between Medicare payments and Medicare costs.

Comments, questions?

DR. ROWE: Just one minor suggestion, Julian. I think you might want to change the title of this, because How Medicare Pays sounds a little bit like a handbook from

CMS on what the rules are. And as you point out in the chapter, you describe these 50 different payment systems but then you also go on to identify the policy issues that are currently and the environment around each one. That's the much more interesting part of this for many readers and I think that you should find a title that reflects the content of this a little better.

If you're going to sell this, you know, get this sold on the bookshelves.

MR. PETTENGILL: Well, first of all, I'd have to share the royalties with about 12 staff here, who all contributed to this. Everybody keeps congratulating me, all I did was edit what they did. The real work was done by others.

MR. SMITH: Whoever did the work, it was quite terrific and Jack and Joe are right. I found it very useful.

Glenn, on your question, the question isn't should we. We do. In every setting that we look at, part of the information that we're working with is total margin information. To some extent, that comes with a look at private payer margins, Medicare margins. So it's in the mix

and it would be foolish to pretend that it's not somehow in the material that we're working with, that it's not part of making the decision.

But it's useful to remind ourselves, I think, that while that's true we tend then to look at access questions. And to ask ourselves is there something about either other payer behavior or about total margin which appears to affect the access of Medicare beneficiaries to high quality care.

That's not an entirely satisfactory exercise, but it is the way we behave. And if you're looking for sort of a paradynamic consistency rule, I think it's useful to ask ourselves whether or not that behavior that we've adopted is as good as we can do given the current state of information and the current reality of the political process.

I don't think we could say to ourselves don't pay attention to that information. We do. We're reminded of it by various people who want to communicate with us. And we include it in our own preparation. Staff includes it in the preparation material. It would be foolish to pretend that we don't take account of it.

The question is having taken account of it, what's the question we ought to ask? And for lack of a more far-

reaching question, it seems to me the one we've sort of stumbled to is access. And does this other information appear to impact on access to high quality care? And if we're going to try to come up with at least a decision framework, I'd suggest we try to do that more formally.

MR. MULLER: I'll add my compliments on this chapter, but also ask through the chapter we have the question of trying to approximate market prices, could they be created in these various areas. Yet we also know, as Dave and other people's comments have implied, the problem is laced through with policy exceptions, whether it's things like DSH, whether it's CAHPS upper or lower, whether it's geographic averaging methods and so forth.

So throughout the whole payment system we have some policy measures of long-standing, some of shorter standing. In many ways, those that have been there long-standing, 20 years or so, have caused people on all fronts to act as if they are part of the program as much as efforts to create market type prices.

And part of what I would like to see reflected in our thinking, not necessarily in this chapter today, is the fact that we have a broad set of policy initiatives that go

beyond the setting of market prices. That's really built into this program.

And while it's fair to say that we should constantly evaluate what's a fair price that Medicare should be paying to achieve its overall purposes and, as David summarizes, if that main purpose is access to care of high quality for a good set of the beneficiaries, then that can be an overarching policy purpose.

But to act as if and talk as if that these policy exceptions are always, in some sense, some kind of violation of the norm, I think is inappropriate because these policy exceptions have been put into the law for many years, DSH for one. We'll come back to that later. There's an important policy purpose there that many people have agreed upon for over 15 years now. And to constantly hold up the fact that somehow there seems to be some violation of economic theory and therefore has to be justified each year I think is an inappropriate suggestion to make, when in fact it has been put in there and it has, in that sense, as much standing over a period of time as a pricing norm.

So I would suggest that as we think and talk about this that some of these exceptions that we have made to what

an efficient provider's costs might be, also be considered part of the policy objectives for Medicare.

Then there's just one technical question. Sometimes we talk about, as the overhead slides did, about whether we're looking at an efficient provider's average costs. And then other times, like in the introductory keypoint paragraph, we talk about an efficient provider's marginal costs. We seem to go back and forth on that. Certainly in programs where Medicare is a big part of the overall funding of the program it's very difficult to hold out the standard for marginal costs as the appropriate standard, if Medicare is basically the game.

Obviously, when they're a very small part of it one can look at marginal costs. So I think we should be a little more consistent in how we use the marginal costs, average costs language because obviously anything like SNFs and so forth, to kind of suggest that you're only going to pay for marginal costs and so forth, I think would be an inappropriate suggestion to make.

But again, my summary point is these policy exceptions which are laced throughout the program, there's not just one or two, do have standing after a while. And to

somehow suggest that they have to be rejustified each time I think would be an inappropriate suggestion to make.

MR. HACKBARTH: Since I was the initiator of this discussion, let me just leap in here for a second. Clearly, it is the prerogative of the Congress to make these policy exceptions. And by definition when they do it, it confers legitimacy upon them. They are the constitutional actors here. So the question is not whether they are legitimate or not. In fact, reasonable people can disagree about the wisdom of them. I wouldn't suggest for a second that there is a right answer to that.

The issue that I'm trying to get at is more narrow, and that is specific to MedPAC. One of the most important things we've got, our ability to influence the policy debate, is dependent to a large degree on our consistency of thought and rationale. In that sense, we have a different test applied to us than the Congress. The Congress has legitimacy through the Constitution. Our only ability to influence things, though, is based on how compelling our arguments are.

And so we need to be consistent, I think, in a way the Congress does not. If we want to influence the policy

debate, I think some rigor of thoughts, consistency of rationale, is much more important for us than for the Ways and Means Committee or the Finance Committee.

And so, without presuming to say this is the right answer and that's the wrong answer, I want us to always be asking the question are we being consistent in how we think about, for example, the issue of whether we consider total margins or not? Are we being consistent in how we do it for urban hospitals and rural hospitals and free-standing skilled nursing facilities and renal dialysis providers?

I think if we get into the habit of saying well we'll do it here, maybe not there, that the cumulative effect of that sort of haphazard decisionmaking over time is to weaken the credibility of MedPAC as an organization, lessen the impact of our recommendations.

We have a peculiar specific role in this process, this policy process. It's a different role than the Ways and Means Committee or the Finance Committee. Our role, as I see it at least, is to try to bring some logic and analysis and through that some consistency to the policy process.

MR. MULLER: Can I just offer a comment? I wasn't

arguing consistency. I was just asking consistency around what norms? I think part of what you're obviously encouraging us all to comment on is what are those norms that we should use across the various policy considerations that we have? I'm just suggesting that market price is not the only norm that we have. It's obviously a very important one, especially in a commission that has payment in its title.

So I'm not against consistency. I'm just arguing there are a few other norms, as well, and I second your sense of consistency makes sense.

MR. HACKBARTH: Ralph, I wasn't reacting specifically to your comment, but just trying to explain why I put this topic on the agenda.

MR. FEEZOR: Thank you. I had followed Ralph's logic a little bit but I'm sitting here looking at a document, because I thought of it in terms of all the other documents that we produce, that it was probably more for external purposes as opposed to internal stimulation and was a little concerned about, I think as Ralph touched on, telling Congress that perhaps they should not do certain things or to laden this program because there were

references in there that Julian made about it's not a very efficient way to address the policy means and it may not be very efficient from an administrative standpoint. It may be very efficient from a political enactment standpoint. I thought that was a little naive.

Having said that, and I'd turn to the experts on the Hill conduct like Sheila, but I suspect that the temptation of policymakers in this city to look increasingly at the Medicare fund to serve purposes is going to increase in the time of budget deficits or shortages. And therefore, the timing of the debate or the question you've raised maybe suggests that while we -- and I respect your efforts to try to make sure that we, at least, provide a rigorous question and some consistency of thought -- that it may well be, if we can do it in a fashion that makes some sense, raise some questions for a larger audience than just ourselves.

MS. RAPHAEL: I think what we're trying to do here is kind of build a bridge here between the real world that we inhabit and a theoretical model. If we were developing a blueprint for the Medicare program today it would be very legitimate to take a look at what are the objectives, how well targeted are they, what are the tradeoffs, et cetera.

But we already have inherited a number of these that are embedded in the Medicare program. And in terms of building that bridge, two points. First of all, I separate out the issue of total margins from other public goods because to my mind they are separate issues.

In terms of total margins, I would subscribe to David's approach, which is I think that we have considered total margins and I think we all can take a look at it in the context of access. What do we know about total margins? And to what extent could it affect access for our Medicare beneficiaries to one, just services per se, and to hopefully high quality services?

So I would be in favor of somehow continuing to take a look at that in our decisionmaking process in a consistent way across all the sectors.

I think when we come to the public goods, which is providing for uncompensated care or trying to look at what were training efforts or trying to make sure that people got enhanced patient care and other public goods, I think that that is more difficult. And I think where we could make a contribution, and have, is taking a look to what extent those programs, in fact, have met their objectives as best

as we can define the objectives. And I think we've done some of that as we've taken a look at DSH and taken a look at IME.

So that would kind of be my thoughts about how to approach this going forward.

DR. ROWE: Two points. One is I think this discussion probably fits better in Jack Ashby's chapter on assessing payment adequacy than it does in this chapter, the first chapter that describes how Medicare pays and what the issues are. Because we can write that first chapter in a fairly objective fashion without making statements about what we think about which is the right variable, total margin, inpatient, et cetera.

MR. HACKBARTH: This material that Julian presented this morning will not be included in the first chapter. I just want to underline that for people. This is separate from the first chapter.

DR. ROWE: Right. I think it's very relevant to the discussion we had last month with Jack and we'll probably have again. And he shows these slides of all the things to take into account, access, access to capital, et cetera.

So I think that this discussion should be embedded somehow in that chapter, in terms of whatever decisions we make.

Second is, I guess increasingly, as I listen to our discussions, I'm concerned about the emphasis on margins. And I'd like to propose a variation in our nomenclature, in our thinking. I think what we really are interested in is the public goods on the one hand and the financial performance on the other hand. I think there's more to financial performance than operating margins. I'm concerned, as some of you know, about the issues of access to capital, cost of capital, balance sheet, financial stability of these organizations. Making sure they are there.

These institutions go through cycles and we keep seeing all these cycles of earnings. They're up and then we correct because we don't want them up and then they go down. We always overshoot and say oh my goodness they went down too far, so we correct them. It's a hell of a way to try to build a health system that has stable, sustainable access in a quality way to the public.

So we need to make sure that there's a system out

there. So rather than focusing on whether it's the inpatient margin versus the outpatient margin versus the Medicare margin versus the total margin, I would like to also have us consider, pari passu with that, some measure of credit worthiness, balance sheet stability, I don't know what the term is. I'm not an accountant. Thank God these days I'm not an accountant.

But I just think we should broaden our thinking a little bit and there are many people on the staff and even on the commission more knowledgeable than I about these issues. But I think that would be helpful because the cyclical stuff just, you know, having been in the hospital business and seen what happened with the BBA and then having those people say oh, I guess we overshot by $100 billion, we'll give you a little more to try to -- I mean, you just can't run institutions that way.

So that would be my thought.

DR. NEWHOUSE: A couple thoughts on this discussion. On the margin issue, I agree with Carol that the issue is access and I would just suggest that we probably have paid even more attention to changes in margin than to their absolute level as potential indicators of

changes in access. But I also have a lot of sympathy for Jack's point that we may have overreacted.

On the larger issue of the architecture of the payment system, my dominant reaction is if the Congress doesn't want us to comment on this I'm not persuaded we should. But there is one consistency issue I thought I might comment on, which is to what degree should this program try to tailor payments to local markets versus a uniform national program?

We have, in our discussion of the geographic adjustments in the Medicare+Choice program, complained that we have unbalanced local markets in both directions, implying that in effect health care markets are local and we need to take cognizance of that.

On the other hand, the traditional program, other than the wage adjuster, essentially doesn't take cognizance of the program. This surfaces in a couple of places at least in the chapter. One is should Medicare take account of the generosity of Medicaid programs in its SNF reimbursement? I would have said probably not.

The second is if small markets hospitals have a monopoly and get higher total margins should we take account

of that? It's more tempting to say yes there but my guess is that the dispersion across local markets is just too much for this program to handle and, except for the kind of gross violation -- I would have said gross violation -- that we saw in the AAPCC or potentially can see there, that it's just too cumbersome to think of trying to adjust each payment system for local market variation beyond what we have. That's not to say we shouldn't refine the wage adjuster and so on. But obviously one can go quite a bit further down that road and I just doubt its practicality.

DR. REISCHAUER: Let me just say something about total margins and about other public goods. It strikes me that what we're primarily interested in here is that Medicare cover the cost of care delivered to Medicare beneficiaries, but subject to a constraint that we want to keep in business a sufficient number and an appropriate distribution of facilities offering high quality care so that Medicare beneficiaries have access similar to that of the rest of the population to providers. And because Medicare is but one of the payers to these facilities we have to, at times, be concerned about the overall health of the facilities which depends on the payments they receive

from others.

But that discussion, in a sense, shouldn't be merged, as we always do, with what are the Medicare margins. It really should be in the discussion of well, is there entry or exit into this market and what does that really tell us? We put it in the wrong place for what its, in a sense, fundamental purpose is.

And we also don't -- and I'm not faulting the staff, I think it would be terribly hard to do this -- really look at this in a way that would be helpful to answer the question which really has to do with the distribution of facilities and the access people have to it. You can go to a town and it can have two hospitals, each of which have 54 percent occupancy rate. One has a positive margin of 5 percent and the other has a negative margin.

And you say half of the hospitals have negative margins. Do we really care if that one goes out of business and the other one operates more efficiently? The answer is no. I mean or we shouldn't. I mean, preservation of facilities should not be an objective of our recommendations. Only to the extent that you need to preserve facility to provide access in certain areas. But

we all know that there are many areas where we have considerable excess capacity.

And so I, in the long run, would hope that we can refine the way we go about presenting this information and having it affect the recommendations we make.

With respect to other public goods, Ralph's right, these things have been embedded for a long time. They aren't going to disappear. I'm not sure Congress needs to hear from us on them. But it is true, at the same time, that these public goods which have nothing to do with the core mission of Medicare are pursued in a horrendously inequitable and inefficient manner through Medicare or through even Medicaid.

I mean, you think of DSH payments. If the objective is to provide resources equitably to facilities that serve low income people who don't pay their bills or the payment isn't -- why should it be as a percentage of whatever Medicare business they happen to be dealing with? It's the stupidest thing in the world.

It's political. That's why. This is a vehicle for providing resources to some places that achieve this objective in an inefficient way. That's been written.

Somebody should write it again, probably not us.

DR. NELSON: I'd like to get back to the broader issue and the three tentative conclusions which I support. There's this continuing temptation to try and achieve a secondary objective through payment policies. A hypothetical might be if we were to recommend increased payments for Medicare+Choice in order to increase the drug benefit availability.

I would like to also support the where do we go from here, insofar as moving toward having these conclusions become sort of the way we do our business within the Commission, to have this as a caution about the possibility of secondary objectives and adhere to these conclusions.

MR. SMITH: Very briefly, Glenn. I thought Bob got the discussion of margins and of how we ought to think about margins in terms of a broader concern for the appropriate sizing and access of the system. I think that's exactly right and I think Carol and Jack were headed in the same direction. There's a lot of information that we ought to pay attention to. Margins is only part of it. Entry, access, capacity, capacity utilization are the pieces of the same pile.

On the public goods thing, Bob, maybe it's inefficient but I think we ought to admit the possibility that maybe it isn't inefficient. There is a question for us to ask about the utilization of Medicare to provide public goods, is how well does it work, rather than whether or not Medicare is the right vehicle. It doesn't make any sense for us to talk about that, Ralph is absolutely right. This stuff is embedded in the system. For better or worse it's going to stay there.

We can contribute to an efficacy discussion rather than an appropriateness discussion. And I wouldn't assume, as it seemed to me you said, that simply because you wouldn't invent Medicare as the vehicle to try to provide the public good, that it is therefore in efficient. I think that's a testable hypothesis and we ought to be more neutral about whether or not these things are efficacious or not and the efficacy question is the one, as Carol said, that we ought to focus on.

MR. HACKBARTH: I think the issue is whether these formulas in fact target the dollars in a way that you achieve the public policy goal. I think that's the question Bob was raising.

Okay, Julian, thank you for provoking some thought and discussion. Craig is now going to provide some more background information about the indirect medical education adjustment. Craig?

MR. LISK: Good morning. I'm going to go a little bit more into more specific concerning Julian's discussion and the discussion you had now about the IME adjustment and the amount of the IME payments that are above the costs of teaching in the current payment system.

Teaching hospitals have historically had higher costs than other hospitals and Medicare IME payments are intended to pay for the higher costs of teaching hospitals. The IME adjustment was provided, back at the beginning of the prospective payment system, in light of doubts of the inability of the inpatient PPS to fully capture factors such as greater patient severity that might account for these higher costs in teaching hospitals. The adjustment is an add-on to the base payment rate so it's adjusted depending upon what the per case base payment rate is for a specific case.

These payments total somewhere between $4 billion and $5 billion currently.

The adjustment, though, is set well above the current cost relationship. It's more than twice the empirical cost relationship between our measure of teaching intensity, resident-to-bed, and costs per case, Medicare inpatient costs per case.

Inpatient operating costs per case increase about 3.2 percent for every 10 percent increase in their resident-to-bed ratio but the adjustment in 2002 is set at 6.5 percent. That's been the adjustment level that we've had since 1999.

In fiscal year 2003, though, the adjustment will drop to 5.5 percent as part of policy changes that are from the BBA and as this adjustment has been deferred over a number of years to finally it will be reduced to 5.5 percent.

But this next table will provide you some information on the IME adjustment under alternative scenarios. To give you some idea of the size of the adjustment that these hospitals receive currently, what they will next year, and then what really the empirical level says, and if we're going to pay closer to what the cost relationship is for Medicare.

As you can see, these are substantial payments. So a hospital with an IRB of 0.5 currently receives an adjustment of about 29 percent currently. The empirical cost relationship is about 17 percent. So there's a substantial amount of payments above the cost relationship here for these hospitals.

To give you some idea, though, about particular hospitals and the size of the IME adjustment, I'll give some ideas of some competitor hospitals for some of our commissioners. The University of Chicago Hospital, for instance, has an IRB of .75. Mt. Sinai has an IRB of about .56, but your competitor --

DR. ROWE: For historical interest only.

MR. LISK: Of historical interest, yes. But Montefiore has an IRB of .75, for instance. If you get down to hospitals that are around the .25 area, you have like St. Raphael in Connecticut, which is a competitor to Yale New Haven Hospital. If you talk about even lower numbers, .10 is something like Maine Medical Center is an example of that. So that just gives you an idea of the types of hospitals and where they fall in that distribution.

But this next chart here shows you the frequency

distribution of hospitals by IME adjustment percentage. As you see, almost half of all hospitals receive less than a 5 percent increase bump up in their payment due to the IME adjustment of teaching hospitals. However, 10 percent of teaching hospitals receive more than a 25 percent boost in payments from the IME adjustment. So it's a substantial portion of the teaching hospitals. That's more than 200 teaching hospitals overall.

You have to remember, this is saying what the boost in payment is from the IME adjustment. Many of these hospitals are also receiving DSH payments and stuff. So their payments above the base rate are substantial. So those are the amounts that are, in terms of above the cost relationship.

So this translates into potentially much higher margins for these major teaching hospitals. As this next chart shows, it shows into greater financial performance under the Medicare program.

There still is wide variation and overlap in inpatient margins, but the red line shows the Medicare inpatient margin for major teaching hospitals in 1999. As you can see, they have substantially higher inpatient

margins than other hospitals. And for performance for other teaching hospitals, which is the green line.

The aggregate inpatient margin for major teaching hospitals here in 1999 was 22 percent compared to 6.5 percent for non-teaching hospitals and 11.6 percent for other teaching hospitals.

But the IME payments above cost and DSH payments are the substantial contributor to this. As you see in the next overhead, when we remove the DSH payments and IME payments above the cost relationship, the distributions are much closer and overlap considerably.

Interestingly, though, aggregate performance for major teaching hospitals, though, is still higher than other teaching and non-teaching hospitals. The aggregate margin still for major teaching hospitals is 5.6 percent, for other teaching is 4.3 and it's 2.5 for non-teaching hospitals.

The story for total margins, though, is different. This is historically, when we get down to the IME debate, is one of the reasons why this is such a critical issue. The margin for major teaching hospitals, total margin, is 2.4 percent compared to 4 percent for other teaching and non-teaching hospitals. Now again, there's a distribution

around these margins. This is just the aggregate, so there's considerable overlap in the distribution here, as well, on total margin performance. But in aggregate, the financial performance of major teaching hospitals is lower.

What I want to talk about is the payments above the current cost relationship and what this means to these teaching hospitals. In 1999 the subsidy portion of the IME payment accounted for about 3 percent of Medicare inpatient payments. So it's a substantial portion of Medicare inpatient payments.

The subsidy portion of the IME payment accounted for 8.8 percent of Medicare inpatient payments for major teaching hospitals, so it's a large share of their inpatient margin.

The subsidy portion, though, also accounted for 1.8 percent of total revenues for major teaching hospitals. Thus, it was a major factor in helping keep major teaching hospitals total margins above zero. Without these payments, and assuming no behavioral change if they didn't have these actual subsidy payments from the IME adjustment above the cost relationship, the aggregate total margin for major teaching hospitals would have been about 0.6 in 1999. So

that's an important factor.

Another thing to consider, though, is the subsidy portion of these payments will be dropping about 30 percent next year, in terms of the IME adjustment, when it's reduced.

All our discussion, when we get back to it, on the updates and the modeling we have done have all taken that into account in all of the numbers that you've seen and you saw at the last meeting. We've taken that into account, that the IME adjustment is dropping to 5.5 percent, and all the margin calculations that you'll be seeing later on. So that's just a reminder to that. We're talking about payment adequacy.

DR. ROWE: You said the subsidy piece goes down 30 percent? That's because the subsidy piece is half of the 6.5, is basically what you're saying?

MR. LISK: Correct.

DR. ROWE: But it's going to 5.5. So the total payment is going down 15 percent?

MR. LISK: Correct, absolutely.

The next overhead, in terms of other factors to

consider here in determining what to do, several factors need to be considered. First is the provision of uncompensated care. Uncompensated care accounts for about 10 percent of major teaching hospitals' total costs, compared to 5 percent for other hospitals, on average. Interestingly, though, the real difference here though is between public and private. Public major teaching hospitals, their share of uncompensated care is around 30 percent. The private major teaching, on average, are very similar to the rest of the hospitals, closer to 5 percent. It may be little bit higher but it's very similar.

Again, there's a wide distribution here on provision of uncompensated care but on average the private major teaching are similar to the other hospitals. So it's the public major teachings that, on average, have the higher burden.

Teaching hospitals, though, in relation to this also receive about two-thirds of Medicare's DSH payments. It's about one-third/one-third for major teaching and other teaching.

I'm sorry I didn't mention this, major teaching we define as hospitals with a resident-to-bed ratio of over

.25. That accounts for about a quarter or 20 percent of all teaching hospitals. But on DSH payments they each account for about a third.

Interestingly though, the private payer payment-to-cost ratio for major teaching hospitals -- this is from the AHA data -- is lower for major teaching hospitals compared to other hospitals, 1.07 compared to 1.16 for other teaching and 1.24 for non-teaching. So potentially there may be some of the subsidy is going to help support lower payments from private payers is one thing we have to consider. We don't know, in terms of what actually happens and how hospitals behave, but it's interesting to note that.

Now if we look at our overall Medicare margin for major teaching hospitals, that's about 11 percent margin, I believe. So if you're looking at Medicare may be more generous than the private payers here overall for the whole facility.

Another point that I want to make though is that IME payments are not directly tied to any specific mission that the hospital has except the level of teaching intensity that the hospital has. There's no direct use of what these payments are to be used for in the payment system. That's

something that Julian had brought up in his discussion, in terms of one of the factors to consider here, as well. So there's no direct system on how to say to use this.

MR. HACKBARTH: Craig, before you leave this, you've pointed out that the amount of uncompensated care in major teaching hospitals is twice as high as the other. Is it possible to do a correlation, hospital-by-hospital, of the relationship between IME payments and uncompensated care? Because even if in the aggregate the recipients of the IME have, on average, higher uncompensated care, the relationship might look very different if you go hospital-by-hospital.

MR. LISK: Unfortunately, the data we use directly for us to do it on the uncompensated care is the AHA data that we don't have direct access to, that the AHA has access to. So it's something that we'd have to figure out for them to conduct for us because we don't directly have that data.

So all this leads us to the following issues we would like you to consider. The first, should Medicare continue making extra payments to providers unrelated to the costs of caring for Medicare patients? That was one of the main issues that Julian was talking about in his

presentation.

Related to that then, in the IME adjustment, is should the IME adjustment be reduced to the empirical cost relationship? And if so, how quickly and what should be done with the savings if you wanted to?

So the options for the commission, in terms of this discussion is really to remain silent on this regarding this year's March report but study this issue more comprehensively next year in what you want to do. Now historically, on the level of the IME adjustment, ProPAC had, for instance, looked at this on a yearly basis, had recommended that the adjustment be reduced closer to the empirical level but gradually and monitor financial performance over time. I just wanted to provide that as a brief recap, but that was something that was done annually.

You could, though, if you wanted to, in this year's report, recommend reducing a subsidy portion of the IME payment for some specified period. And if you do, you'll need to decide whether to return the subsidy to the base rates or take the IME subsidy as program savings.

With that, I'd be happy to answer any questions and look forward to hearing your discussion.

DR. NEWHOUSE: Ever since I got to ProPAC I agreed with their position in principle: if Congress wants to spend the money this way, fine. But it's hard to justify.

I thought, however, there is an analysis that we could do that's not here that would shed some light on what I think is probably a relevant question. I don't think it, in fact, would be that difficult for us to do it.

The issue you alluded to, Craig, is to what degree do IME payments compensate for changes in how private payers behave. You have an interesting cut of numbers in the paper we got that you didn't put you. You have hospitals divided into four groups: those that get IME and DSH; those that get IME only; those that get DSH only; and those that get neither.

The total margins are actually highest in the hospitals that only get IME and they're lowest in the hospitals that get both IME and DSH, which I suspect is kind of minor teaching versus major teaching.

But if you took those same four groups and you looked at how total margins changed over time as IME changed, that might tell us something about whether as IME went up or down these hospitals were making adjustments in

what they were charging private payers. In other words, their ability to maintain themselves as IME went down. Or DSH for that matter, I don't really want to separate the two for this purpose.

That might inform our discussion. I haven't seen that kind of analysis before, but it's analogous to what we've done with the payment-to-cost ration in general which suggests that rates that are obtained from private side do change as Medicare benefits change.

DR. ROWE: Can I comment on that point? I know we had seen the analysis, Joe. I think Julian may have shown us a kind of reciprocity or mirror image analysis about Medicare payments and private payer payments in the past. But then I thought more recently, perhaps at the last meeting, we had seen some data that indicated that those things had not been so closely linked of late. And that in the last year or two that hadn't been the case. Is that right?

DR. NEWHOUSE: That's right.

DR. ROWE: So given that, that calls that into question. I think if you're going to do that analysis, I would be careful to pay attention to rural because I think

that what happens is rural teaching hospitals -- like the University of Iowa, a very large teaching hospital in a rural area -- are indispensable in the networks of private payers and have very high payment-to-cost ratios independent of whether they're getting IME, et cetera. The rural effect would screw up that analysis unless you were paying attention to it, I think.

And I do think that since that relationship seems not to be holding most recently, we might soften the supposition that you're saying that there is this linkage.

DR. STOWERS: I think this goes back to our earlier discussion, too, but my concern lays somewhere with the other teaching. And looking at total margins in 1999, I would assume based on the 6.5 percent, that was being received at that time. You know, we have a 2.4 for major teaching, other teaching of 4 and non-teaching of 4. It just makes me wonder why it makes sense at that point, when we've come to that kind of a balance for teaching and non-teaching, that we would not be making a recommendation to hold it to 6.5 percent rather than allow to go on down to the 5.5, taking into everything into consideration if we're going to look at total margins.

Now I know that gets back to looking at Medicare margins versus total again, but let alone be talking about taking more and more of the subsidy, why when we're at that level of balance between 80 percent of the hospitals, which is the other teaching -- and as Jack said, very instrumental in the broader area across the country to maintain a supply of health care providers.

So as we look at this, I'm just wondering why we're talking on down lower and lower.

MR. HACKBARTH: It sounds to me like you're applying a little bit different test than Bob was talking about when you look at total margins. What I heard Bob suggest was that total margins are relevant when you're looking at the issue of preserving access to care for Medicare beneficiaries. What I hear you suggesting is well, we ought to be looking for equality or rough equality in total margins. Those are very different tests.

DR. STOWERS: I realize that. But I think if we are looking at access and these other teaching hospitals are instrumental throughout a broad area. So if we do look at purely from access, I'm just wondering why we would not still apply something to margins there, as to where we are.

It would seem that we had come to some kind of a balance at 6.5 and yet the majority of the discussion is still on cutting the subsidy more and more. So it would seem to me we were about right at the 6.5.

DR. REISCHAUER: Craig, these total margins are all-payer margins?

MR. LISK: Yes.

DR. REISCHAUER: And they exclude resources that hospitals might have from annual gifts, endowment earnings, parking?

MR. LISK: No, they would include those factors, too.

DR. REISCHAUER: They're included in here? Okay.

MR. LISK: The other thing to consider on the total margin though is that historically, and it's always been true, that major teachings total margins have always been lower. Unfortunately, I can't remember, this difference that we currently have may be about what has been in norm or it may, in fact, even be closer. You can't quote me on that because I don't have those numbers with me now.

But I know that the total margin increased from 1998, from when it actually did go down in the first year

after the BBA.

DR. REISCHAUER: I have a presentation suggestion, and that has to do with the distribution charts that we get and, in a way, the tables, also. We have the first one, which is distribution of Medicare inpatient margins. It shows major teaching hospitals on the whole have much higher margins than others. And then you note well, they get some other kinds of payments, and disproportionate amounts of these other kinds of payments. And then you remove both DSH and above-cost IME.

I can see a good case for including another distribution table which just removes DSH. DSH is for something else. And then we want to ask ourselves well, for the payments that are really associated with Medicare, are we giving them in a sense too much and their margins are higher? And how much of this gap here, in these distributions, is due to IME above cost and how much to DSH?

If it's only a small amount, I'd say let's not lose a lot of sleep over it. I suspect it's not. I suspect, especially having heard those numbers for Ralph's hospital -- former hospital -- there must be some inefficiencies in having eight residents around each bed.

DR. LOOP: I think that we should study this further rather than making any recommendations now. The biggest problem is this is 1999 data, and teaching hospitals are probably not doing well in 2002. In fact there's a AAMC paper that suggests that half of the teaching hospitals will have negative margins this year. So I think we need an update on the plight of teaching hospitals before we make any conclusions.

There's one point that you made on page four in the last paragraph before issues. I was curious what documentation you have that teaching hospitals could negotiate lower payment rates with private payers because of the subsidy. I've not heard that before and I know it's been discussed here. But do you have any documentation that that occurs?

MR. LISK: No, but it may also be evidence that they're paying the same rates as everybody else and not paying a premium, either.

DR. NEWHOUSE: That's what I was trying to get at by asking for the analysis.

DR. LOOP: I know you were. We always try to get higher payment rates with private payers and not negotiate

lower payment rates. I just wondered...

MR. LISK: In terms of negotiation, it may provide some flexibility for the hospitals, given if they're looking at what their total bottom line is to negotiate what otherwise would be a lower rate. If they didn't get those rates, the hospital may end up being tougher in its negotiation with the private payers.

But there's no evidence of that. That's just theoretically what you would suppose would happen.

MS. BURKE: Craig, first of all, let me congratulate on summarizing what is a complicated history for our support of IME. But let me, if I can, underscore Bob's point to start with. I think in this analysis going forward, and whether we decide to do something this year or study it over a longer period of time, which I think makes sense, I think you have to separate out DSH from IME in the conversation.

They are two very different structures and two very different strategies. The decision to do one was very different from the decision to do the other. As is evidenced in the early part of your paper where you talk clearly about the fact that we, at the time of PPS, really

weren't sure what it is we were doing as we sat around trying to draft that. And in fact, were trying to address what we believed to be an issue, the DSH scenario was a very different one.

So I think, first of all, let's separate these out in terms of conversation and talk specifically about what our intentions were with respect to IME.

I also think we can't underestimate, even as we try to do an analysis, of ultimately -- I mean, we can be helpful in providing information on what the numbers actually tell us. But at the heart of this is really the politics, of the support of a mission, that is the support of a particular mission that takes place in teaching hospitals in varying degrees and what Medicare's role ought to be in that broader mission.

I don't think anybody's confused about the fact that this is not always specific to Medicare patients. But we were very clear about our intention to essentially subsidize an activity that we believe helped the system broadly.

So I think we ought to be careful about assuming that's a pejorative because I don't think it was at the time

that we did it. And I think we ought to be careful about making statements like well, this lets them negotiate lower rates. I don't think the facts necessarily bear that out and I think we ought to be careful about how we state that, in terms of a basis upon which we'll make a decision on a rate.

So I think A, separate it from DSH. B, let's think about where we want to go with this. And C, let's recognize that a lot of this is the politics of the mission that was debated at the time and then nobody is confused about the fact this is all about Medicare. It's whether we use Medicare dollars for other purposes, which is exactly the point that Julian tries to raise as we have to get into that. But it's not just going to be a function of how numbers move around in terms of what those margins look like.

MR. LISK: On the DSH part, as we had talked about that back at the office, and unfortunately what we took was off-the-shelf stuff that we had done as part of our other analysis for doing this. Because we were very conscious about that issue.

MR. MULLER: I'll be very brief. I'll add to the

DSH pile-on though. Obviously, since we add DSH revenues and not DSH costs, the margin is always going to look much higher in any table where there's a lot of DSH. I would just reiterate that point.

Secondly, remind me how we do the calculation of what the empirical level of costs are? You relate it to the IRB ratios? Just a brief description for me.

MR. LISK: Basically it's a regression analysis where the teaching component -- we account for other factors that are in the payment system that are cost-related factors, wage index, case-mix, and outlier payments, and those factors, and hospital location. And teaching adjustment picks up everything that's unexplained, basically.

MR. MULLER: Now is not the time for it but we know that the IRB ratio is the way in which the funds are distributed and people, for a long time, have been trying to figure out a better way of distributing it because I think everybody realizes it's a difficult way of distributing. Whether using IRB ratio is the best way, therefore trying to figure out what the costs are, I think is a point we should consider more fully.

I'll do that one offline but I do think it's not the best measure.

MR. LISK: That's always been an issue.

MR. MULLER: People can't easily come away with a better one, but there's a lot of inaccuracy, both on the payment side and therefore I would assume on the cost side, in using it. I don't have a better one at the moment, but I'm just saying we can't extrapolate too much therefore from using it as a kind of all else is attributed to that kind of variable.

DR. REISCHAUER: Craig, just to correct something that was wrong, the cost associated with uncompensated care, in other words the DSH costs, are included in the total margins.

MR. SMITH: Sheila made my point. Let me try to take this back to the earlier conversation. Having a discussion about the appropriateness of the IME subsidy using margin data runs in the wrong -- runs away from what I thought you talked about sensibly 45 minutes ago. Sheila's point is we need to connect this conversation to the mission. We have no information about the appropriateness of the payment to the mission. It would be an enormous

mistake working with simply margin data -- and one year's margin data as Floyd points out, a year which probably isn't very representative. To make a recommendation to cut these payments further seems to me enormously inappropriate at this point.

We ought to follow the let's put it off and study it, but we need to study it in the broader context. We won't be better off six months from now if we're still looking at annual margin and total margin and Medicare margin data in order to try to figure out whether this payment's appropriate. That's not why it's there.

DR. REISCHAUER: David, you aren't suggesting that we say that the cut that's supposed to go into effect in 2003 not go into effect, are you?

MR. SMITH: I didn't, but I might.

DR. REISCHAUER: I think Floyd was.

MR. SMITH: Ray made that point already and I'm not unsympathetic to that. But that wasn't my point, Bob. My point was we should not at this point recommend any additional cut or any pattern of going forward to try to reduce it to the empirical level.

MR. DEBUSK: David covered my point, but as a

matter of curiosity, what is the dollar spin on indirect medical education payments above the cost of teaching? What is that value?

MR. LISK: Next year we estimated it's between $1.5 billion and $2 billion, is what we'd say for next year.

MR. DEBUSK: One other comment. How can we even begin to try to make decisions on some of this stuff when this data is ancient? It's so old it's, in many cases, useless.

DR. REISCHAUER: But that goes for almost everything we do.

MR. DEBUSK: Good point, Bob.

DR. ROWE: Can I ask, Bob, why you're so surprised at the concept of suggesting that the additional BBA dictated cut not occur? I mean, you really seem surprised by that.

DR. REISCHAUER: It is the law of the land, and Congress has assessed this issue two years in a row and pushed it off. And whatever evidence that we have right now suggests that even after this cut goes into effect there will still be substantial overpayment for IME. So I'm sort of saying okay, what's on the other side of this? And I

think on the other side of this is we have old data and things are changing rapidly. That doesn't seem to stop us anywhere else.

MR. SMITH: But, Bob, part of the dilemma here --

DR. REISCHAUER: But if we did do what Jack suggests, we're making a recommendation to Congress.

MR. SMITH: But in this case, the will of the Commission sounds to me not to make a recommendation to Congress. But the more important point is if what we were buying was IME, your point would make sense. But clearly, we're buying something else. And we don't know much. We don't know enough to say we don't want to pay what we're paying because we don't know enough about what we're getting and the appropriateness of this level of subsidy.

To argue that we ought to cut it because it isn't necessary to pay for IME ignores Sheila's very important point about how we got to where we are. We're not here because we're precisely price or cost the cost of medical education. That's not what we're doing.

DR. REISCHAUER: Sheila will tell you that we got where we were because we scared to death that PPS was going to savage these hospitals. And it turned out that it

didn't. And in fact, some of them laughed all the way to the bank.

MR. HACKBARTH: We need to bring this to a conclusion. Clearly there's no consensus on this issue right now, so this is one we'll have to come back to later on. We have a lot of issues where we don't have that option of coming back later on and we've got to move on to those right now.

So thanks, Craig, for getting everybody awake and stimulated. Now we go into a series of presentations and discussions related to updates for fiscal year 2003. We're going to have a brief introduction, as I understand it, from Jack and Nancy on assessing payment adequacy and then a background piece on input prices from Tim and then we'll go into physician services. Nancy?

MS. RAY: Thank you. Jack and I are here to briefly review our approach for updating payments in traditional Medicare.

As we see in the diagram, we use a two-part approach for updating payments and traditional Medicare. The first step assesses whether payments are too high or too low. In each service area we tried to look at evidence

about the appropriateness of current costs and the relationship of payments with appropriate costs. If evidence does suggest that payments are either too high or too low, then the update recommendation would include an adjustment to the base payment rate.

The second step of our approach is to try to measure how much efficient provider's costs will change in the next payment year. Our approach accounts for expected cost changes primarily through the forecast of input price inflation, an estimate of how much efficient provider's costs are expected to change in the coming year, holding constant the quality and mix of inputs providers use to furnish care and the types of patients they treat.

Then the final update, as depicted in this figure, combines the two percentage changes.

Today you will be making payment recommendations for six fee-for-service service sectors. We will be applying this two-step framework in each of these service sectors. We will be asking you to come to conclusions about payment adequacy for each of these sectors and about expected changes in efficient provider's costs in the coming year.

Jack and I would be happy to address any questions you may have about your mailing materials or my very brief overview. Tim will immediately follow our presentation with a more in-depth analysis of measuring changes and input prices for fee-for-service providers. Following that, Kevin will present the physician payment update. And then, immediately after lunch, you will consider updating hospital payment rates and you will be considering both inpatient and outpatient together.

Then to conclude your day you will be presented with payment update discussions about dialysis, home health, and SNF. That's all I have.

MR. HACKBARTH: Okay. Tim?

MR. GREENE: Good morning. I will be discussing the section of chapter two dealing with input price measures used to update payment rates. I will conclude with a draft recommendation on treatment of wages and input price measures. This is both to review the section in the March report and also as background for the further discussions of updates as we proceed.

The section in the draft recommendation are at tab D of your briefing materials.

All the payment systems operated by Medicare use input price indexes to determine price change. CMS and the Congress use these measures to update payment rates and you use the measures and market baskets in your decisionmaking on payment update recommendations.

This returns to some of our discussion from last month. Most input price indexes are calculated by constructing a weighted sum of individual price measures. First, input categories or components are identified to reflect the range of products that a provider purchases to produce patient care. For each input category a price proxy is chosen to measure price changes and is weighted by its relative importance in provider purchases.

For example, the input price index used in the inpatient PPS uses 10 proxies for wages and salaries, 10 for employee benefits, and 20 for all other non-labor related costs other than capital. The other price indexes are comparable or involve somewhat smaller numbers of cases.

Briefly, the input price measures used by CMS in the price indexes generally use producer price indexes from Bureau of Labor Statistics and various wage and benefit measures also from BLS to measure input prices and labor

costs respectively.

CMS uses a different input price measure for each Medicare fee-for-service program. The inpatient prospective payment system uses the PPS hospital input price index for operating costs and a capital input price index for capital costs. These are referred to respectively as the PPS hospital operating market basket and capital market basket respectively. The operating market basket is used both for inpatient services and also to update the outpatient prospective payment rates.

The payment system for hospitals paid under TEFRA rules, which are exempt from inpatient PPS, use a market basket referred to as the exempt hospital market basket. The payment system for SNFs uses a SNF market basket similar to the hospital market baskets. Similarly, the home health agency PPS uses a home health specific market basket.

CMS does not currently maintain a market basket to measure prices or update payments for outpatient dialysis services. However, BIPA required that the Secretary develop such an index and we understand it's currently under development and will be reported by this coming July.

Finally, the sustainable growth rate system for

updating physician payments under the Medicare fee schedule uses a measure called the Medicare economic index. I'll be discussing that as we go along but Kevin will be coming back and discussing it in greater detail during his presentation.

As we discussed last month, major policy issue in the design of market baskets is the treatment of wages. Labor costs combining wages and employee benefits account for over half of total expenses in the market baskets we look at. That ranges from about 61 percent for PPS hospitals to almost 78 percent for home health agencies.

As you know, wage levels and trends for health care workers often differ substantially from trends in the overall economy. For example, staff shortages now affect a number of health care occupations, pharmacists, registered nurses and so on. These may lead to wage changes in coming years that may differ substantially from trends in the overall economy.

Proxies for labor costs used in market baskets can be chosen on a number of grounds. First, they may be based on wages and benefits paid to employees in the general economy or to employees in the health sector overall or for individual settings, like acute care hospitals or skilled

nursing facilities.

In addition, in designing market basket, one needs to specify what occupations one is looking at, professional employees or all employees or whatever. Here we might be looking at occupational categories that apply to the general economy or that may be specific to the health sector overall or to individual settings, again hospitals or whatever.

In practice, though we may want to have occupational categories specific to health care and types of occupations, we generally have to make tradeoffs between occupational specificity and industry specificity, that is health care or health sector health individual settings. Generally, BLS does not provide wage and benefit indices specific to narrow categories such as hospital nurses or nursing home professionals and so on.

Finally, in the 1980s, policymakers were concerned that inclusion of health industry wage measures in the PPS hospital market basket would allow hospitals to increase wages more rapidly than necessary, thereby increasing the market basket in future Medicare payments. Consequently, CMS made extensive use of wage and benefit proxies from the general economy in constructing its market basket. It did

so basically as a cost containment measure to prevent this feedback effect of industry behavior effectively determining future payment rates.

In the 1990s now, pressure from HMOs, other private insurers, and from public prospective payment systems has increased substantially. We think now that the concern with unwarranted wage increases as a way to game the system is misplaced now and is not a source of concern. It's no longer a reason to avoid using health or industry or sector specific wage proxies as was feared 10 years ago.

Increases in health sector wages have not tracked those of the general economy closely since 1990. Here I compare the employment cost index of BLS wage and salary measure used in many of the market baskets for using their employment cost index for all health care workers on one hand and all workers in the general economy on the other.

As you can see, from fiscal year 19990 through fiscal year 1993, the employment cost index for wages of health care workers increased more rapidly than the index for employees in the overall economy. This reversed and was followed by six years during which health care worker wage increases were significantly less than those in the general

economy. The differences were substantial with average annual wage growth for health workers 1 percent faster from 1990 through 1993 and then 0.8 percent lower from 1994 through 1999, when the trends reversed again and health wage growth has exceeded that for the economy as a whole.

The differentials led to a cumulative divergence between health wages and general economy wages that amounted to 5.2 percent over the six year period. Now over the entire 1990 to 2001 period, the divergence in this period is offset by movements the other way in other periods, but six years is a long time to see a differential develop and grow.

As I indicated earlier, health labor costs can and, as we've seen here, have diverged greatly from those in the general economy. The prospect of staff shortages of the sort I mentioned raises the possibility of future wage increases which may continue the pattern we're seeing now of health care wage increases exceeding those in the general economy for a period.

These health sector wage increases would differ from those in the general economy, would not be reflected by use of wage and benefit proxies based on general economy trends. On the other hand, use of health sector specific

proxies in the market baskets would automatically reflect the effects of staff shortages if they occur in the market basket forecasts and eventually in the updates made for Medicare payments.

I will now turn to the draft recommendation on the treatment of wages and CMS market baskets. This addresses directly and specifically the use of general economy versus health specific wage and benefit measures in the market baskets. We suggest the Secretary use more appropriate wage and benefit proxies in all input prices indexes used for updating payments, the ones we're discussing now.

In particular, we suggest that in determining index weights, relative importance to attach to various proxies in calculating the market baskets, measures specific to health sector and health sector occupation should be emphasized, should be given greater weight. As you can see, in table 2.1 of your briefing materials, CMS makes substantial use of index specific to individual settings in the health sector as a whole, and in the existing market baskets.

However, this choice does not appear to be a guiding rule. And in particular, the weight given to

general economy indexes is substantial. In the case of hospital market baskets, both PPS and exempt, approximately two-thirds of wage growth is explained by indexes for wages in the general economy compared to one-third for hospital workers. This has the effect, as described earlier, of not reflecting health specific wage growth in the calculation of the market basket.

We can discuss the recommendation now and we'll consider drafting --

MR. HACKBARTH: Tim, I think I understand the overall issue, but I'm not sure I understand the specific language of the recommendation. As I understand the overall issue, all other things being equal we would like the input price measures to accurately reflect the costs of the various provider groups. And we're concerned that that doesn't happen now because they're not using health sector specific wage measures.

The reason for not doing that historically was the concern about this feedback effect, that if we gave them health specific wages that it might be inflationary. Concern about the feedback has diminished because of pressures in the private market and so it's less of an issue

than it seemed at one point in time.

So the general direction we're suggesting is let's use health specific measures of wages and benefits, which incidentally would help avoid problems due to shortages, for example, of nurses. If there are shortages of nurses there won't be a direct feedback into our input price measures.

So that's sort of the big picture, as I understand it.

Now the draft recommendation has two sentences in it. The first says the Secretary should use more appropriate proxies, wage and benefit proxies, as opposed to saying the Secretary should use health sector specific proxies. Why not say health sector specific? More appropriate is sort of a vague term.

MR. GREENE: We're trying to be as broad as possible. In some cases, such as the MEI, there may not be very narrowly targeted physician --

MR. HACKBARTH: Specific where available, or something like that?

DR. NEWHOUSE: I had written in the same change, but I would address Tim's issue by adding at the end of the sentence -- so I would say the Secretary should use health

specific wage. And then at the end of the sentence I would say for occupation categories where health industries have large shares. Now that leaves large to be defined. For janitors, we'll use some kind of index appropriate for janitors. For nurses, we'll use nurses.

The other thing, I would make a stronger statement in the text about the reason for the feedback mechanism. I think it's flawed. The feedback mechanism assumes hospitals nationally collude on their wages, which doesn't make any sense. I don't think it's managed care that did this in. I don't think it was ever there.

MR. HACKBARTH: I think both arguments were in the text.

MR. GREENE: The first one you're making, which is probably the more important, doesn't get as much attention and emphasis.

MR. HACKBARTH: I agree with the substance of your point. Now the second sentence in the draft recommendation in determining index weights, measures specific to the health sector and its occupation categories should be emphasized. I guess that's fine as it stands.

DR. NEWHOUSE: I think it can go.

MR. HACKBARTH: Just eliminate it all together?

MR. GREENE: That's important because as I indicated, and as you can see, CMS does make extensive use of health industry measures now, and uses civilian hospital employee measures for a large part of the hospital market basket, but it gives them relatively low weight, one-third in the hospital market basket.

So the question of relative importance is crucial. We can't simply say use health industry measures, especially when they don't exist or are not immediately on target. And that doesn't get around the fact of when you use both you want the health industry measures to have the greatest weight. So the weight point is important.

DR. WAKEFIELD: Tim, I think you make a really good case for this recommendation and I support it and even more the refined language that's just been recommended. I've got a related question.

Do you have any idea how difficult this will be for CMS to do, if they chose to do it? And how long that process might take? Part of the reason why I'm asking you this is because I don't know if it's the case or not, but I remember in our June report we made a recommendation dealing

with wage index that asked for a faster phase-out of the teaching physician and resident cost from the wage index, for example. And again, I don't know if this is true or not, but I heard that to operationalize that recommendation was going to be quite difficult for CMS to do. I'm not sure if that's the case, I don't know if staff ever heard that or not.

But that concern that I heard prompts this question now, and that is again, have you any idea how long it would take for CMS to actually operationalize this recommendation or how difficult it will be for them to do? Reiterating that I strongly support it.

MR. GREENE: I think it's straightforward. We're not talking about primary data collection, developing new indexes or anything. We're talking about choosing among basically existing Bureau of Labor Statistics measures and incorporating those choices as part of their regular rebasing and market basket revision process, which they will be undertaking now. People from CMS are here and can reply or qualify that if they wish.

But I think it's a series of judgments that will be made in an ongoing process at this time.

MR. HACKBARTH: So this could happen for 2003, fiscal year 2003?

MR. GREENE: I believe so.

MR. HACKBARTH: This is a draft recommendation that I think actually is in response to conversation that we had. So I think there's full support for this, so I don't want to spend any more time than is necessary.

MR. FEEZOR: I was just going to echo, I think, something more akin to what Joe indicated would be something I'd be very supportive of. But just one question, Tim. Nursing turnover in many hospitals normally runs 15 to 20 percent a year, and increasingly it seems that signing bonuses and other economic and some non-economic incentives are provided as a means to attract labor. I'm just curious, how does that get captured in wage indexing? Any idea?

MR. GREENE: I'm not sure. I don't know the BLS data that well. I gather that the, at least until recently available BLS data, it was not reflecting significant increase in nurse wages but I don't know the data firsthand and I can't give you a concrete response.

MR. HACKBARTH: So the draft recommendation would be amended to say, the Secretary should use health sector

specific wage and benefit proxies?

DR. NEWHOUSE: I would add at the end, for occupation categories where health industries have large shares. Where you have a small share you're not going to have a health industry specific index anyway.

MR. HACKBARTH: Like a janitor. Given that those are pretty minor changes, I don't think we need to have this brought back tomorrow. Are people prepared to vote on this now?

All opposed to the draft recommendation?

All in favor?

Abstain?

Okay, thank you, Tim. Kevin, physician services.

DR. HAYES: Good morning. We have two topics to cover this morning. The first has to do with replacing the sustainable growth rate system and the second has to do with an update recommendation for 2003 for physician services.

I've got seven slides here, the last one on the update recommendation, the other six having to do with replacing the SGR system. They're all closely related. I could go over them in just about any order. It would probably be best for me if we just go through them all,

including the recommendations, and then come back for discussion.

The first thing I'd point out is that our work on replacing the SGR system is timely. The conference report for the Labor HHS Education Appropriations bill that was passed by the Congress last month included a request for a MedPAC study on this issue. The conference report language began with an expression of concern about the 5.4 percent reduction in payment rates that went into effect January 1st and went on to ask that MedPAC study replacing the sustainable growth rate with a factor that more fully accounts for changes in the unit cost of providing physician services. Findings and recommendations are due March 1st, which is the due date for our March report, so addressing this issue in the March report will fulfill this requirement.

Which brings us then to our first draft recommendation, having to do with how the Congress could replace the sustainable growth rate system. This recommendation really has two components. The first has to do with repealing the sustainable growth rate system and instead requiring the Secretary update payments for

physician services based on the estimated change in input prices for the coming year.

This, of course, is the update method that we've been talking about throughout the fall for other services, the one that Nancy summarized just a few minutes ago. And so there's not much more to say about that.

But there are a few things to say about the second component of this recommendation, having to do with the adjustment for productivity growth. There is another recommendation to follow in a few minutes on the details of multifactor versus labor only productivity. But for now let me just say that the recommendation is proposing here that there be a reduction in the update for productivity growth.

We are proposing no such reduction for other services on the assumption that cost decreases related to productivity growth will be offset by cost increases due to scientific and technological advances and other factors.

In the case of physician services, it's not clear that those other cost increasing factors, S&TA and such, are great enough or large enough to offset productivity growth when it comes to physician services. So this recommendation has that clause in it.

The other point that I would make about this recommendation is that it implies that the Congress has the option of deviating from updating payments based on changes in input prices for any given year. The Congress, of course, has done so many times for inpatient hospital care, for example, and could do so if this recommendation were adopted.

The next slide talks about the rationale for the recommendation. It's really aimed at making the update method for physician services similar to that for other services. This would take us a step toward making payment policy for physician services more consistent with that for other settings.

The other thing that would be accomplished here is that it would solve problems with the sustainable growth rate system. It would allow the updates to better account for factors affecting costs and it would decouple payment updates from spending control. In effect, what the Commission is saying with a recommendation like this is that the update mechanism is not an appropriate tool for achieving spending control.

To make this all happen, we have a slide here

which has to do with next steps. Several steps would be necessary here. The first one, of course, would be changing current law to repeal the SGR system. Also, there is the matter of changing the measure of input prices that's available, the Medicare Economic Index, changing it to a forecast. This is something that the Commission recommended in its March 2001 report. It seems to make sense in that the whole idea behind updating payments is to anticipate changes in cost for the coming year. The MEI currently looks backward at payment changes for the previous year.

Other useful steps have to do with the productivity growth adjustment that's in the MEI currently. The Commission talked at the December meeting about the advisability of separating out that productivity adjustment and considering it separately in update decisions.

The other thing to say about productivity growth has to do with that current adjustment. It currently applies or addresses just changes in the productivity of the labor inputs and we could see a rationale for changing that adjustment to make it apply to all inputs.

That brings us then to our next recommendation, which is that the Secretary should revise the productivity

adjustment for physician services and make it a multifactor instead of labor only adjustment.

The first thing I would say is that multifactor productivity is a measure of changes in productivity for all inputs, labor and capital. And a rationale for adopting this recommendation would be first that both types of inputs are used in the delivery of physician services. Labor inputs are very important, of course, but other inputs, capital related inputs having to do with office space, supplies, equipment and so on, are also relevant.

The other point to make about this recommendation is that changing the productivity adjustment would make it consistent with modern methods for analyzing productivity growth. The current labor only adjustment in the MEI has been in place more or less in its current form since 1975 when the MEI was created. Since the Bureau of Labor Statistics has done a lot of work to improve methods and data available on multifactor productivity.

For calculations in the draft chapter, we assumed an adjustment for multifactor productivity of 0.5 percent. That's a standard that the Commission has used for other services. Current data from the Bureau of Labor Statistics

suggests that perhaps that adjustment is a little low.

Next, we should talk for a minute or two about the budgetary impacts of replacing the sustainable growth rate system. They are important and I'd like to deal with the two impacts individually.

The first has to do with removing spending control. As you know, the sustainable growth rate system is a tool for achieving spending control. It does so by establishing a target, if you will, for growth in the quantity and intensity of services that Medicare beneficiaries receive, physician services. That target is growth in real GDP per capital. If the SGR system is replaced, that target will no longer be relevant.

Any difference between real GDP per capita and growth in beneficiary use of services will no longer be fed back through to payment rates via the update mechanism. And so, taking that feedback loop away will result in an increase in projected spending for physician services. As you can see here, it's 0.6 percent.

The other spending impact has to do with changing the productivity adjustment. The current adjustment out through 2006 is 1.6 percent. If we were to replace that

with the productivity standard that the Commission uses of 0.5 percent, we've got a difference of 1.1.

Now that assumes that that phrase in the first recommendation having to do with lessen adjustment for productivity growth stands. But if that goes away, then this estimate would go up by 0.5 percentage points.

So we have a total spending impact estimated of 1.7 percent per year.

So if we apply this new update approach to information we have for 2003, we come up with an update recommendation of 2.5 percent. This is the estimated change in input prices for physician services, a forecast for 2003 of 3.0 percent. And then less that productivity adjustment of 0.5 gets us to the 2.5 percent that you see here.

That's all I have.

DR. ROWE: When would this occur?

DR. HAYES: January 1, 2003. The update cycle for physician services is calendar year.

DR. REISCHAUER: I was wondering why we recommend to the Secretary, or to the Congress, a procedure or a method here for updating that isn't as sophisticated as the one we've adopted for ourselves? I mean, we've adopted for

ourselves a system where we first look at the base and say is it adequate. And yet, there's nothing in here saying that the Secretary should consider that.

And while S&TA may not be important right now, it might be important five or 10 years from now. Maybe we should include productivity net of any cost increasing factors like that. I mean, why shouldn't we be recommending, in a sense, a full hand to Congress and the Secretary, when we're using the full hand to make a recommendation?

DR. HAYES: My reply to that would be, on the issue of payment adequacy, whether the current base is right, recall the point that the Congress can step in and change the update in any given year based on recommendations from us, on CMS, having to do with these matters. When we look at language in the Social Security Act on the update for say inpatient hospital care, it's just like this. It's the market basket increase. Sometimes it's adjusted up or down in a given year. But otherwise, it just says market basket increase.

And so the discretionary part of the process of considering access and entry and exit and all that kind of

thing would be something that the Commission would include in its update recommendation to the Congress and then it would be up to the Congress to deviate from what's described in the recommendation.

DR. REISCHAUER: But we were there a year ago and we decided to change. It strikes me that it's useful not only to have the MedPAC staff look at the adequacy of the base, but if the Secretary and CMS staff were also trying to answer that question, we might get a better answer to it on which Congress could then base its decision.

MS. BURKE: Bob, are you suggesting a change in the statute that references that? I mean, in recommending a repeal of SGR, are you suggesting that we replace that in a statutory way with language that requires a certain presumption in setting rates? Or are you just saying in directing the Secretary? I'm just trying to understand your intentions.

DR. REISCHAUER: We are suggesting that SGR be repealed. Now something is going to have to replace it, and presumably you would have language saying these are the considerations that the Secretary should take into account, just we've taken them into account.

MS. BURKE: As a general matter you don't do that in statute.

DR. REISCHAUER: In the report that you would --

DR. NEWHOUSE: We did do it in PPS.

MS. BURKE: We did do it in PPS.

And we have done it historically in nursing homes and other places. We've gone through this game in a variety of ways.

DR. REISCHAUER: I'm just thinking about the confusion that would result if the Secretary is supposed to come up with something that is a prospective judgment on price increases minus multifactor productivity and it comes out to 3 percent and MedPAC comes along and says it really should be 6 percent because our judgment is that the base is horrendously inadequate. And then everybody makes a big deal out of a difference that may not exist.

In fact, the Secretary might think no, that they're dead on, the base is too low.

MS. BURKE: I'm always leery of statutory language if you can avoid it, if we can achieve our end some other way. Once it's there it's tough to...

DR. ROSS: I was just going to ask Bob, sort of by

extension when we get to the hospital discussion and the other facility discussion, are you going to add that in, too? I guess I'd parallel Sheila --

DR. REISCHAUER: You can defeat me now and I'll shut up.

DR. ROSS: That's up to the other commissioners, not to me, but I guess the question is do you want to give the Secretary total discretion here? Because that's essentially what you'd be saying if you put this in statutory language.

DR. REISCHAUER: The question is whether you're asking the Secretary to provide a judgment about prices or a judgment about what he thinks the increase should be.

MR. HACKBARTH: Maybe the middle ground here is that for purposes of protecting the relative prerogatives of the Congress and the Executive branch, the Secretary ought to be asked to do this: say what the increase in input prices with the multifactor adjustment would be, invite the Secretary in language to suggest other considerations for the Congress to take into account just as MedPAC does. But not write a statute that basically gives the Secretary carte blanche to determine the proper update. So invite comments

to supplement this number, this calculation. Don't grant the Secretary, in statute, absolute freedom.

MS. BURKE: Can I just ask a factual question? If in fact we are successful in our suggestion that we repeal SGR, what remains in the statute, specific with respect to physician reimbursement?

DR. HAYES: There's everything about the fee schedule, of course, which is geographic adjustments and relative value units and the whole thing, requirements for updating the relative value units from one year to the next to make sure that the relatives among services are right. And that's it.

MS. BURKE: Let me just suggest that before we go down this road, if we're going to come back to this, let's actually factually find out what's in the statute before we start playing around with making statutory recommendations, other than the repeal which is explicit. But let's do a reality check in terms of what is already in the statute and whether what we want to do going forward is statutory or by nature of language recommendations.

I mean, I don't know whether the statute needs changing at all, other than the repeal.

DR. NEWHOUSE: I think Bob is right, it has to be replaced with something because it, itself, replaced the VPS which then came out of the statute. Now this is there, it's going to come out of the statute so there's just a void on the update mechanism, basically.

MS. BURKE: So what's left?

DR. REISCHAUER: Is the Secretary's recommendation or whatever he comes up with the default unless Congress acts?

MS. BURKE: That's what I -- I mean, I want to look at 18 and see.

DR. REISCHAUER: If that's the case, as opposed to just the Secretary making a recommendation about what he thinks the increase in price is going to be. You know, we've said less an adjustment for growth and multifactor productivity. The number we've put in, 0.5, I'm not sure that's a consensus among economists of multifactor productivity. I thought it was closer to 0.7 for the economy as a whole.

MS. BURKE: Whether you put the number in the statute or just the process?

DR. REISCHAUER: No, you put in the process but

we're going to come up with a different recommendation, even if we see the world the same way if our view of multifactor productivity is different from BLS' or BEA's.

MS. BURKE: Let's just step back and take a breath and see what's actually there.

MR. HACKBARTH: So there are two questions about what's there. One would be, if we repeal SGR what remains with regard to physician services? Then the other is exactly how are all the others structured? And what we want is some parallelism between where we end up with physicians and what we have for the other providers, inpatient hospital, et cetera.

DR. ROSS: That's what the recommendation on the table would give is consistency with, I believe, almost all of the other payment systems in Title 18.

DR. NEWHOUSE: Productivity adjustment, which we think is a legitimate distinction.

DR. ROSS: No, with MedPAC framework it's consistent with that.

DR. NEWHOUSE: It's consistent, yes.

DR. ROSS: The reason you don't see it explicitly, say for hospital services -- well, I won't say the reason

it's not in Title 18, but MedPAC's going in position as you've discussed is that the default until you see otherwise is market basket and the Commission has tentatively reached the judgment that increasing costs associated with scientific and technological advance are approximately offset by a policy judgment that they'll be financed with a productivity adjustment.

Here the assertion that staff have brought you is that most of the increases that we can think of through S&TA are likely to come through new codes being introduced. So it's automatically taken care of in that mechanism and we're adopting the same standard for, if you will, financing those, so to speak, with an explicit adjustment for productivity.

And that's why you'd write language slightly differently for the docs than you would for the hospitals.

MR. HACKBARTH: What I like about this approach is that people can read the boldface recommendation and get a clear sense of the direction that MedPAC is suggesting we go with physician services. We're not writing statutory language, really, here.

I think then in the text beneath the boldface

recommendation we can say the MedPAC framework involves an assessment of payment adequacy in various factors. And we would love and we're sure the Congress would love to hear whatever analysis the Department can bring to bear on those issues, as well.

DR. REISCHAUER: I will accept that as an adequate response.

MR. HACKBARTH: The second draft recommendation, the Secretary should revise the productivity adjustment and make it a multifactor instead of a labor-only adjustment. I just need a clarification, Kevin. The 0.5 percent, or Bob's now suggesting 0.7 percent might be the number, those were 10-year averages or something like that, right?

What I'm trying to get at is are we asking that each year the Secretary look at the most recent BLS number on multifactor productivity and have it balance up and down? I understand these numbers do move a lot due to cyclical changes in the economy. Or are we suggesting a number that's smoothed and it reflects long term trends?

DR. HAYES: What I can tell you, I think that this recommendation gives the Secretary some discretion over how to proceed. That discretion is consistent with current

policy. The labor-only adjustment in the MEI is a 10-year moving average. And so the assumption would be that the Secretary would go through a process, as was done in the past, to determine the labor-only adjustment and decide what kind of factor would be appropriate but in measuring multifactor productivity.

MR. HACKBARTH: What has MedPAC done in the past? For example, on the hospital side, we have looked at long-term averages as opposed to adjusting our policy factor up and down based on cyclical changes in the economy.

DR. HAYES: I might invite my colleague Jack Ashby to the table to explain that, but my understanding is that it was a matter of looking at the experience with multifactor productivity in the early to mid-90s and setting a target.

MR. ASHBY: Right, that 0.5 figure was indeed a 10-year average, also. But it developed a couple of years back. And as both Kevin and Bob have alluded to, we've had a couple of years of high productivity growth in the meantime, so the average has probably risen a bit.

But let me also comment that when we developed this in the hospital context, we didn't necessarily think of

it as being as precise as a rolling 10-year average that we would adjust every year. As long as it was generally capturing the long run phenomenon, we were going to leave it at that 0.5. But in this context, you might take a different answer and suggest that it formally be a 10-year rolling average.

MR. HACKBARTH: The point I want to make is not to tie us into a particular formula, but I hate to see this balancing up and down. I think some stability --

DR. REISCHAUER: I don't think it bounces as much as your bad dreams might think it does. And I think maybe in the text if we say something about a trend productivity, without making it clear whether it's the past trend or the future trend, it will give the --

MR. HACKBARTH: That would get to my point, yes.

DR. REISCHAUER: And whether it's five years or 10 years or whatever.

DR. HAYES: Just from a historical perspective, the very reason why CMS adopted a 10-year moving average on labor-only productivity was because of the bouncing around problem and a need to smooth it out a bit. And so I'm not recalling exactly when that change was made, but that is

certainly the rationale for it.

MR. HACKBARTH: Good. I like Bob's idea. The point here is trend as opposed to annual.

Also, in this same draft recommendation, multifactor is technical language that many people in our audience won't understand. Could we use something like account for the productivity of all inputs, as opposed to just labor? David can even improve on what I offered. But multifactor sounds a little bit too much like technical jargon for our reports. It can be in text, but not in the recommendation.

DR. NEWHOUSE: But there is formally a number that corresponds to multifactor and is labeled multifactor productivity.

MR. HACKBARTH: Again, maybe I'm making too much of this but I think a big percentage of our audience reads only the recommendations and I'd like them to be able to understand the recommendations when they read them. We can include multifactor productivity in the text explaining it, for those who delve more deeply.

DR. REISCHAUER: I would suggest you go the other way around. Leave multifactor here and explain it in the

text. It is a technical term and there is a line in the BEA numbers that has multifactor --

DR. NEWHOUSE: It's like trying to say we should use the output of all goods and services rather than GDP.

MR. HACKBARTH: I give up. Do I have to roll on my back?

DR. ROWE: So let me make sure I got the record straight. The chairman suggests that we make the recommendations so people understand them when they read them, and other people disagree with that recommendation.

[Laughter.]

DR. REISCHAUER: Why do doctors do everything in Latin?

MR. HACKBARTH: Any other comments? Are we ready to vote?

DR. NELSON: Are you receiving comments on the narrative at this point?

MR. HACKBARTH: Sure. I welcome comments on the narrative.

DR. NELSON: I'm making these comments on the narrative with the understanding that there are going to be audiences reading this report for whom some of these points

are important, apart from the Congress.

On page six, Kevin, in talking about beneficiary access to care, the point is made that evidence of widespread problems with access means that the payments are too low. But in the absence of that the payments are probably about right or may be too high.

I'd like to see that sentence deleted because quality could still be up, even though payments were too low. And it implies that physicians would take care of a diabetic or a patient with a heart attack differently depending on the payment source, which I think is generally not the case. This is mainly in the context of a quality reference, not the access reference.

With respect to the willingness to serve referenced on page seven, again just pointing out that the willingness of physicians to serve Medicare patients is based on '99 data when the updates were high. I'd like to see a sentence that qualifies that and expresses some concern that with a reduction in the conversion factor, perhaps in 2002, that the impact of that is not been measured at this point.

On page nine, in accounting for the cost changes

in the coming year, the impact of the regulatory burden may be substantially higher with the impact of the HIPAA requirements. I think it's worth a sentence to point out, since looking forward, indeed the costs associated with that may be substantially larger.

I think our assessment of the PLI premiums may be understated since in many parts of the country those premiums are exploding. A sentence to reference the unknown impact of that, it seems to me, wouldn't hurt the report. It's true that these practice expenses are accounted for in the RUC process, but there's a five year lag in that process. So our estimates of that in the costs should include those.

Finally, on page 14, you talk about increasing productivity and the potential for new technology to be applied in that context with some examples of new technologies that are expected, perhaps, to improve productivity. I think it also wouldn't hurt to have a sentence pointing out that new technologies may also decrease productivity, depending on how productivity is defined.

But if you're talking about the number of patients

that a doctor can see or the efficiency in their work product, things like e-mail, which increase the work but aren't compensated, aren't paid, so they aren't reflected on the inputs and may very well diminish productivity.

MR. FEEZOR: I just wanted to underscore Alan's comments on the PLI, and particularly that's a cyclical issue. But when the spikes occur, as they do after major events and disruptions in the market such as we've had this year, we had in the late '80s, they do jump up. And I question whether we capture that fast enough.

And then if you look, particularly on the provider institution side, with the major withdrawal of one of the major professional liability carriers from the marketplace right now it's likely to really spike it up going forward. So I think he makes a good point and our report ought to at least try to capture some of that dynamic.

MR. HACKBARTH: Any other comments? Are we ready to vote?

I think where we ended up in terms of the wording of the draft recommendations basically reflect the issues that were raised in the accompanying text, as opposed to modifying the recommendations themselves. So we will vote

on the drafts as written, as presented.

Draft recommendation number one, all opposed?

All in favor?

Abstain?

Draft recommendation two, all opposed?

In favor?

Abstain?

And number three, opposed?

In favor?

Abstain?

DR. ROWE: Can I ask a clarification?

MR. HACKBARTH: After the vote?

DR. ROWE: Yes, after the vote. Bob made the point that we had a 0.5 and the equations called for a 0.7. We're not even doing it the way we're suggesting it be done. Is our recommendation bakes in this 0.5, as opposed to what's in the literature, if you will? Where did we wind up on that? We haven't reconciled this; is that right?

DR. REISCHAUER: Implicitly, by recommending a 2.5 percent update we've accepted 0.5. We've been unclear, we're using a dated 10-year moving average of multifactor productivity. The CBO has an estimate, a prospective one.

BEA has a more updated one for the past.

It's not going to move around by more than 0.1 or so, 0.1 or 0.2. So it's not something to lose a great deal of sleep over, I don't think.

DR. ROWE: So this is consistent with where we want to go?

DR. REISCHAUER: Yes.

DR. ROSS: And, Jack, it's consistent with where you've been on the facility side. In the next cycle we're free to revisit if you want to refine things. But you're after the decimal place.

DR. ROWE: Thank you.

MR. HACKBARTH: Good job, Kevin. Thank you. We are to the public comment period.

DR. SCHAEFFER: Good morning. My name is John Schaeffer, a practicing cardiologist from one of those areas that Dr. Nelson referred to as experiencing increasing malpractice costs. I'm also the managing partner of a 23 physician cardiology group on the west side of Cleveland.

I've stepped out of the cath lab where all the high tech drama is and I've resorted to the more mundane techniques of talking to patients and listening to patients,

and doing the same with my partners so that we can coordinate not only patient care but a business plan so that the outcome is, in fact, high quality and cost effective care.

I'm here representing the American College of Cardiology. I am its current Chairman of the Economics of Health Care. I'd like to provide these following comments.

The American College of Cardiology is a 28,000 member not-for-profit professional medical society and teaching institution whose purpose is to foster optimal cardiovascular care and disease prevention through professional education, promotion of research, and leadership in the development of standards and guidelines and formulation of health care policy. The College represents more than 90 percent of the practicing cardiologists in the United States.

The ACC appreciates the opportunity to provide this verbal comment and written statement to MedPAC regarding the SGR as it relates to the Medicare physician fee schedule.

MR. HACKBARTH: Sir, could I interrupt just for a second. I screwed up in not reminding everybody of the

ground rules for the public comment period, so bear with me while I do that.

We do have a limited amount of time and I'm sure we will have a number of people who wish to speak. So I would ask all people commenting to keep their comments as brief as possible and avoid reading prepared statements.

I will also reserve the right, when people speaking to the same subject start to repeat one another, in the interest of hearing a variety of different viewpoints, I'm going to urge people to move on.

We need to do this in order to be fair to everybody in the room. Thank you.

MR. SCHAEFFER: Thank you. What I wanted to do was make some comments regarding an additional methodology that the Commission could consider in terms of evaluating the adequacy of effectiveness of Medicare physician payments.

As you know, currently it's tied to the GDP and the growth of services. That has resulted in the 5.4 percent decrease for physicians. For cardiologists, it's 8.6. For other colleagues of mine, it's even greater.

We're very appreciative of what MedPAC is doing

and the ACC obviously wants to work with the AMA and any other specialty organization that can contribute to the solution of these problems.

We believe that the key stumbling block is the fact that the Congress is unable to resolve whether or not the payments are actually inadequate. As quoted by your statement in March, policymakers and analysts have been frustrated, however, by the lack of unambiguous indicators that might suggest answers to these questions. As you stated, the Commission looks at payment rates based on volume of services, provider costs, product content, provider entry and exit, and most importantly, beneficiary access to care.

All of these measures present formidable challenge of interpretation and none provide conclusive evidence about the appropriateness of the Medicare's base payment in any setting. For example, cardiologists simply do not have the financial or ethical ability to stop accepting Medicare patients. For us it's about 50 percent of our practice. Obviously, cardiovascular care and aging go hand-in-hand.

Physicians can react to inadequate payment plans by not providing care. Obviously, we can use less expensive

and presumably less skillful staff, equipment and supplies, which might have an effect on the quality of care. Physicians could also reduce their costs by not providing some of the expensive diagnostic and testing and treatment that we do in our offices, and shifting those into a hospital setting.

What we'd like to suggest is an alternative way to looking whether or not current payments are adequate. According to CMS data, 124 million services were performed annually in physician offices that would have qualified for a separate payment if performed in a hospital outpatient department. A rough estimate is that Medicare is paying about one-third less when these procedures are done in the office. This results in about a $3 billion savings.

For example, an echocardiogram. The practice expense portion of this is $146 reimbursed to us in the office. In the APC or hospital outpatient department it's $196. That's a $50 difference. We have numbers of 1.5 million echos done, that translates into a $75 million savings that Medicare would experience if done in an office setting as opposed to a hospital setting.

It may be possible for the Commission to more

accurately and quickly assess the adequacy of Medicare payments to physicians by assessing shifts in site of service. Historically we've all seen things going into the physician's office, out of the facility setting.

Medicare payments update formulas are different for different providers. Only for the physician is the payment tied to the volume of services.

Our recommendation today is that Medicare consider assessing the shifts in the site of service where these are being performed. If inappropriate trends are observed, this information would be an early indicator that payment was, in fact, inadequate. Patients will still have access to care, but it will be in a higher cost setting.

And finally, we would also request that any replacement of the SGR not be tied to volume but rather to the cost of providing those services.

Thank you. The ACC appreciates the opportunity to make these comments.

MR. HACKBARTH: Thank you. Next?

MS. McELRATH: Sharon McElrath with the AMA. I just want to make one short comment, and that is in the text of the discussion, I wish you would emphasize that the

productivity factor in the service industry is typically a great deal lower than productivity across the economy.

One of the things that happens is that because the manufacturing productivity factor is so much higher than everything else when you're looking just at the general economy, that brings the whole thing up. So it does lead to a higher productivity factor than we think it is possible for physicians to achieve, particularly in the regulatory environment that they operate in today.

DR. NEWHOUSE: Can I respond? Sharon, I think in principle you're right. It's just that our measurement of productivity in the service sector is much more error-prone than elsewhere.

MS. McELRATH: It just would suggest going down a little bit from where it's going to end up when the CMS just looks at the BLS number for the economy.

MR. HACKBARTH: Any other comments? Hearing none, we'll adjourn for lunch and reconvene at 1:00.

[Whereupon, at 12:01 p.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]

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AFTERNOON SESSION [1:02 p.m.]

MR. HACKBARTH: Let's get started. We have a series of presentations now related to payment adequacy and updates for hospitals. Jesse, are you going to lead the way?

MR. KERNS: I'm going to open our presentation with a review of the hospital financial performance under Medicare that you saw last month.

First, the overall Medicare margin in 2002, our best estimate, which includes payment policy changes that were slated for 2003, creates a margin of 3.8 percent. The only thing that has changed since December is the rural margin went up a couple of tenths of a point since I was able to remove a few more critical access hospitals from our 2002 estimate. This did not have enough of an effect to change the overall all hospital estimate.

Next is just a brief review of the inpatient margin because we're here today to discuss and decide on the inpatient payment update. Again, our estimate of the inpatient margin in 2002 remains at 10.8 percent, as in December. This does include the reduction in IME payments slated for 2003.

The next slide, similar to the slides you saw this morning in Craig's presentation, shows the distribution of the inpatient margin values by hospitals by hospital location. Along the bottom of the graph we show hospital margins in 5 percentage point increments and the side bar has the percent of hospitals in each margin category.

This first graph shows the margin that includes all DSH and IME payments. These payments create the bulge on the right side of the distribution for large urban hospitals.

We note that the distribution for each of the three groups is fairly wide and that there is substantial overlap among the three groups. In other words, the differences among hospital margins within a group are far more pronounced than margin differences between groups.

When we consider the idea of margins by group, as in the tables we presented at the beginning of this presentation, large hospitals with high margins dominate because these margins are revenue weighted.

In the next slide we recreated the inpatient margin distribution after removing DSH payments and IME payments above Medicare's share of teaching costs. As you

can see, without these payments the distribution for these three groups is much more uniform. We also note the distribution is still quite wide and the differences between hospitals within the group are much more pronounced than differences between groups.

One other interesting point, the group with the largest proportion of hospitals with relatively high margins, say above 20 percent, is rural hospitals.

DR. ROWE: Say that again.

MR. KERNS: If you see on the right side of the distribution, there is a portion of the rural hospitals, a decent number, that have margins 20 percent or higher. When you take out the DSH and the IME --

DR. ROWE: Medicare margins.

MR. KERNS: Yes, Medicare inpatient margins.

DR. REISCHAUER: These are hospitals where we're counting a hospital with 10 beds and a hospital with 500 the same.

MR. KERNS: Exactly. This is hospital-weighted, which is why the distribution looks a lot different than the aggregate, revenue-weighted margins you saw on the first two slides.

DR. NEWHOUSE: So these are critical access hospitals?

MR. KERNS: Critical access hospitals have been excluded to the best of my ability from this distribution because I'm taking 1999 margins and projecting -- these are 1999 margins and I've taken out those that I can.

DR. ROWE: Do you have the total margins, rather than just -- I would expect the rural hospitals' margins would be much higher than 20 percent.

MR. KERNS: It's interesting you should bring that up. Not in the presentation, but in the overhead slides I prepared, I did do one for total margin by large urban, other urban and rural. Susanne has had that in her back pocket. There you go. Fairly uniform, not what you'd expect to see.

DR. ROWE: Interesting. So what happens is that bulge in the rural gets flattened out when you look at the total margins.

MR. KERNS: Yes.

DR. ROWE: Good. Thank you.

DR. WAKEFIELD: Is this total Medicare margins?

MR. KERNS: No. To be clear, this here is total

margin, all payers, all sources of revenue. We could done this for overall Medicare margins instead of inpatient, but we're talking about the inpatient update.

DR. WAKEFIELD: Just want to be really clear about inpatient, outpatient total, including Medicare and all other payers, versus all Medicare.

MR. KERNS: Yes, that's why I made it overall Medicare margin, rather than total Medicare margin, so there would be confusion.

Even we don't have the slides for this, I did prepare the same graphs for overall Medicare margin instead of inpatient, and they're basically the same as the inpatient. You see the same bulge and you see that when you remove the DSH and the IME, it becomes very uniform.

DR. ROWE: This morning, Sheila suggested removing DSH but not IME, and I think others supported that. You don't happen to know what looks like, do you?

MR. KERNS: I was thinking about this when you were asking about it this morning. To the best of my knowledge, it's going to be about one-third of the impact when you just remove the IME and two-thirds when you just remove the DSH, when it's the portion above. Of course,

it's going to move the same hospitals in the same direction because most hospitals that receive DSH also receive IME, and vice versa.

DR. ROWE: Right, so what you're saying, just to clarify, is if we remove the DSH because that's something else, that that would be two-thirds of the effect of IME and DSH together?

MR. KERNS: This is the rough estimate off the top of my head. But the same thing would happen. You'd see that the bulge would move in and it would look a lot like this one here, that Susanne has just put up. When you exclude just the DSH, you'll probably see more of a rightward bulge in the red line and in the blue line, but the green line isn't going to move too much. They don't receive IME.

MR. MULLER: Just to make sure I follow the proportions, by two-thirds, you say DSH is roughly two-thirds of the effect.

MR. KERNS: Believe, there's somebody behind me, I'm sure, saying that I'm a little wrong. But if you think that DSH and IME are probably -- if the IME payments, if half of that is a subsidy, and let's just say that they're

about the same size to begin with, and you take away half of the IME and you've got two-thirds being DSH and one-third being IME. In terms of actual dollars, I'm sure I'm a little off.

The next step, of course, is to talk about payment adequacy. As you may recall from the last meeting, and from the mailing materials, we reviewed a number of factors in our assessment of payment adequacy. We found no evidence that the cost base was inappropriate. In the 1990s, hospital cost growth was unusually low due to length of stay decline. And from 1999 through 2001, cost growth increased as length of stay decline slowed and hospital wages increased. We determined the cost growth resulting from these trends was justifiable.

So our best estimate of the overall Medicare margin in 2002, after accounting for 2002 payment policy, is 3.8 percent. This appears to be consistent with the conclusion that payments are adequate. This conclusion is fundamental to the discussion that will follow.

MR. DEBUSK: Now define adequate for me.

MR. KERNS: Does it seem too low, does it seem too high, or does it seem within a band of payment adequacy?

Does it seem that 3.8 percent is just to low?

MR. DEBUSK: So we're setting income for the hospitals?

MR. KERNS: I'm sorry? Of course, we've had the same debate last month, how hard it would be to set a target. But if you think of a band of adequacy, is it plausible that 3.8 percent falls completely below the band of adequacy?

MR. HACKBARTH: I think the silence is assent in this case. At least that's the way I interpret it. Correct me if I'm wrong.

DR. ROWE: I'd just like to comment with respect to comments I made earlier regarding broadening our consideration of the financial component, notwithstanding the social good component, into things beyond just margins and looking at financial stability of institutions, balance sheet considerations, capital considerations, et cetera, credit worthiness, that a 3.8 percent overall margin seems to be consistent -- from the data that I've seen at least -- with an investment grade bond rate. So it seems to be consistent with access to the capital market, which is one of the considerations that I think we should take into

account.

DR. WAKEFIELD: Are we commenting on what has been presented so far?

MR. HACKBARTH: I think the reason Jesse paused is he came to a critical conclusion that sort of lays the foundation for subsequent discussion, namely that the 3.8 percent overall Medicare margin represents something within the range of adequacy. And he's, I think, looking for any reaction to that. So if you have a comment on that particular point, now is the time.

DR. LOOP: I think the 3.8 may be adequate if the figure 3.8 is accurate. I mean, I'm not positive that 3.8 overall Medicare margin is fact. If it is, then okay, that's adequate.

MR. HACKBARTH: As you well know, Floyd, we are plagued with some data issues here. We are working from a relatively old database, older than we usually need to work with. As Murray pointed out earlier today, though, in updating the cost estimates to the year 2002, we think we've used -- the staff thinks it's used relatively generous estimates of the rate of increase in costs. Basically, it's used the market basket, as I understand it, to increase

costs.

Jesse, I'm in over my head.

MR. KERNS: In your mailing materials, the trends that are used for each of these are -- it's not just the market basket. There are a few other indicators we used and there are other adjustments we made. You'd have to review the mailing materials, I can't do it right here off the top of my head.

MR. HACKBARTH: It seems to me like it's an important point. Jack, can somebody just -- if it isn't a market basket increase from '99, can somebody briefly describe what it was?

MR. KERNS: We did use cost per adjusted admission as an indicator and we did also -- several things were factored in. If I had the chapter in front of me I could flip to the footnote. Maybe somebody has that. Good.

So there we are. AHA cost per adjusted admission for 2001 and 2002, and in 2002 a small adjustment for length of stay decline.

DR. ROSS: Let me speak to Floyd's larger point here, though, which is obviously there's some uncertainty about this any way when you try to bring forward three-year-

old data and say what might have happened. We know the payment rules with a fair amount of precision. We have some evidence of what we can assume about input price growth. We've got actual market basket, since we're actually backcasting here.

What you don't know is behavioral change. We don't know, for example, on the outpatient side, what kind of coding response there's been to the introduction of prospective payment system. There's a host of those issues.

Your larger point is well taken, that this is our estimate. Several months ago we introduced a band of uncertainty around that and that's where we turn the ball over to you guys and ask whether you're able to live with those things. But you won't get more precision.

MR. KERNS: I want to correct myself. It actually was the market basket in '01 and '02. We used cost per adjusted admission just for 2000.

MR. HACKBARTH: But there was a conscious effort, as I understand it, to try to err on the side of being generous? For example, in '01 and '02, where it was just the market basket, that implies that there was no change for declining length of stay?

MR. KERNS: There was a small estimate.

MR. HACKBARTH: For '01 and '02?

MR. KERNS: Yes. In an earlier study that Jack Ashby did, he found a correlation between declines in length of stay and change in cost per case of about 0.8 to one. So for each 1 percent decline in length of stay, cost per case would go down by about 0.8 percent.

We adjusted that downward because we thought that might be generous. That study came from a period of time in the mid-'90s when length of stay was going down a lot. I believe we brought it down to about 0.5 to one.

We knew there was a correlation but we didn't want to overestimate it or overstate it, so we reduced it a little. It's a sort of methodological issue. I can write something up on that so it's easier for the commissioners.

DR. ROSS: That's just on the inpatient side. On the outpatient, we did market basket is my recollection.

MR. KERNS: Yes.

DR. ROSS: Even though we'd expect coding improvement in response to the PPS.

DR. WAKEFIELD: Jesse, this is just a comment on the information that we're looking at in the charts on

overall Medicare margin and inpatient Medicare margin. I've raised this before but I'm raising it again.

If ever, and whenever, we can have breakdowns so that we're not lumping all of rural into one category in terms of being able to show distribution, I at least personally find that fairly helpful.

When we're averaging all of rural, large rurals doing fairly well can obscure some of the smaller rural hospitals that are most vulnerable and about which we might be most concerned and not concerned at all about other different categories of rural.

So in the urban, if you just take the urban breakdown, we've got large urban and we've got other urban. We've got a little more teasing out there.

MR. KERNS: So you know, that's not the size of the hospital. That's the metropolitan area in which that hospital is. So you could have a 25-bed large urban hospital.

DR. WAKEFIELD: So you could do it by urban influence codes, for example.

MR. KERNS: You could do it by UICs, indeed.

MR. HACKBARTH: Just so you know, Mary, just to be

clear, the large urban versus other urban is a statutory based distinction. It influences the base rates. This is not an analytical breakdown, it is in the statute.

DR. WAKEFIELD: Thanks for that clarification. I'll still come back to my same point, that I think within this broad span of rural, what we define as rural, we've got different categories of hospitals that are doing better and worse. I went back and pulled our June report, for example, just to look at what our overall Medicare margins, the differences were for example between rural referral centers and other rurals one to 100 beds. Not insignificant differences. All of that tends to wash out.

So I take your point, Glenn, about statutory. But I'm also making the point that I don't think we're concerned about all urban. We're not concerned about the well-being of all rural. But you can wash out those differences when we aggregate, and that is of concern to me.

You especially see that when you look at outpatients margins, for example, between rural referral centers, again using the widest variation. And small rural Medicare dependents. You made a comment that about -- I can't remember, Jesse -- about 20 percent of rurals -- or

that the largest proportion of hospitals that have a plus 20 percent margin are rural hospitals. That's an important point and it begs the question which ones? Is there anything we know about who those are or which ones those are?

MR. KERNS: I can guess.

DR. WAKEFIELD: Or you can guess.

My point here is that periodically in the past we've teased out Medicare margins along these categories of inpatient, outpatient and Medicare overall. And every time we do that I think it's really helpful because it helps focus in on those types of hospitals that are experiencing the greatest problem and those that are coming along just fine, thank you very much. So it's a general point about display of data and helping inform at least my thinking.

MR. KERNS: In the March report we'll do another financial indicators data book in the appendix, so you'll be able to see all the different rural groups that you like.

I would also point out that you're talking about the plight of very small rural hospitals. I brought this up at the last meeting. When we studied these during the June report, there were between 200 and 300, I think it was like

270 critical access hospitals. There's now over 510. There's 2,200 rural hospitals total. At this point, nearly one in four are critical access. They are paid at their costs for inpatient and outpatient, so they're not going to have negative margins, nor will they have positive margins.

DR. WAKEFIELD: And there is that whole other category of possible that still remain and don't have special protection payment policy like Medicare dependent hospital payment policy or --

MR. KERNS: Yes, but at this point there are more rural hospitals eligible for special payments than are not.

DR. WAKEFIELD: So I'm still saying, if I don't know what else is going on with those other hospitals -- first of all, I want to know what's going on with those hospitals, the MDHs, the CAHs, et cetera. But in addition, what's happening to those hospitals that currently don't benefit from any particular payment policy, just like what's happening with large urban versus other urban. And the more we can break that data down the more precise we can be about trying to address any particular problems that might compromise access to beneficiary care, rather than all rural.

MR. KERNS: I would say that the special payment programs are at least intended to isolate hospitals that are important for access, such as the critical access hospital.

DR. WAKEFIELD: True enough, they are, and we also know that the rest of the hospitals have just been put through major changes shifted over to prospective payment. And so with all of those changes, it begs the question what's happening in terms of the financial well-being of those hospitals?

They've been put through, over the last few years, major revamping of the payment systems that they have to adhere to. Does it matter? Are they doing just as well? Or even better than they did before? All of that. See, I feel kind of strongly about this.

DR. REISCHAUER: But, Mary, what if they weren't doing well? If we have a program that says the ones that are critically important for access we'll take care of, and we change overall payment policy and the other ones take it on the chin? I mean, is the function of Medicare to keep every institution alive?

DR. WAKEFIELD: Not at all. But part of what we've just done is change a lot of the payment policy to

prospective payment. So should we at least know what's happening to those hospitals who are experiencing very significant changes? Thinking about outpatient payment policy especially, when we known that for example a lot of rural hospitals do a lot more business proportionately on the outpatient side than on the inpatient side.

So now we've put them through a pretty significant change in a hold harmless that's going to be pulled back before too long, I think 2003. What impact is that having or will it have on those hospitals? All I'm saying is we're making lots of changes. Congress has made a lot of changes in applying prospective payment to different parts of hospitals, and in my interest of rural hospitals.

What, at least as a baseline, is that doing to the margins -- and I'm most concerned about Medicare margins -- but the Medicare margins for those facilities?

Then it begs the next question, what do you do about that once you know it? And is there the possibility that you've got a decrease in access to health care services for beneficiaries in certain parts of the country?

But at least fundamentally, to be able to see what's happening with Medicare margins for those facilities

that are going through very significant changes in payment policy?

DR. ROWE: Could we see the slides again on the distributions?

MR. SMITH: Jack, before we do that, I wanted to raise a question. Jesse, the distribution doesn't tell us anything about beds. It tells us about facilities.

MR. KERNS: It's hospital-weighted so that a very small hospital is going to have as much of an impact as a 500-bed hospital.

MR. SMITH: So that if we wanted to get a more complete picture of sort of what, given the broad distribution around 3.8, of where that distribution affects capacity, at the moment we couldn't tell that.

MR. KERNS: Not from those slides, no.

MR. SMITH: Wouldn't it be important to know that, to get at some of the questions that Bob continues to raise? If we know that the distribution of facilities is very broad, that really doesn't tell us anything about the distribution of low or high margin beds or capacity.

MR. KERNS: Okay.

MR. SMITH: And if we're going to try to pursue

the questions that Carol and Jack and others raised this morning, it would seem to me that would be a critical set of data. Jack, I'm sorry, that's the reason I wanted to interrupt.

I think the distribution material that we have is not really reflective of the distribution of capacity. It's simply reflective of the distribution of facilities.

MR. KERNS: Yes, of the whole market.

DR. REISCHAUER: You could do a distribution of beds here.

MR. SMITH: Right.

DR. ROWE: Could we see the secret slide? Because I'm not a statistician but it seems to me, in looking at this, that there are at least a couple of things that come out. One is that it really doesn't make that much difference whether it's rural, other urban or large urban. Those three lines are pretty much on top of each other.

The second is that there is a reasonable amount of central tendency toward here. This is a relatively kurtotic distribution. Therefore, if we're concerned --

DR. REISCHAUER: A what?

DR. ROWE: Kurtotic.

DR. ROSS: You mean akurtotic, I think.

DR. ROWE: Kurtosis is the central tendency. If you had very little on the outside and a big spike in the middle, that would be more kurtosis, right?

DR. NEWHOUSE: Kurtosis is the fatness of the tails.

DR. ROWE: Then it's akurtotic. We're going to look this up.

DR. REISCHAUER: Are you going to operate on the right leg or the left leg?

DR. ROWE: You know, Bob, you're the only person in America who still thinks I'm a physician. I'm really pleased.

The point I'm trying to make, with a lot of interference here, is that there is a central tendency here. That is, there does not appear to be, at least at this global level of analysis -- and I agree that we should look at other levels. But I also understand that if we torture the data enough they'll admit to anything, so we will find something.

There doesn't seem to be a bulge anywhere with respect on the downside of the places really at risk here.

There's a relatively central tendency here. There's not this bulge at the extremes. And it doesn't seem to matter whether it's a large urban area, other urban, or rural. I think that's informative.

MR. KERNS: Could I make the point before we go too much further? I think we're getting ahead of ourselves. The point of this is to decide whether the total amount of money in the system is adequate. There are distributional issues that are going to come up. It's a long presentation. Jack Ashby is going to talk about a number of distributional things we could do.

When we talk about the plight of certain groups, that's getting ahead of the question of whether the overall amount of money in the system is adequate.

MR. HACKBARTH: Good point, Jesse. And I would like to get to the other points of the presentation. So the issue that Jesse put on the table is is 3.8 percent overall Medicare margin within the zone of adequacy? I heard a little uneasiness from Floyd, simply based on the fact that it's relatively old actual data that we had to roll forward. I think that's an anxiety that all of us share on a whole lot of topics. It's not particular to this one.

Do people generally feel comfortable with the conclusion that 3.8 percent is in the zone of adequacy? If so, I would like to move ahead so we can get into some of the more detailed distributional issues.

MR. SMITH: Glenn, I guess I'm not sure because I'm not sure that it's evenly distributed.

MR. HACKBARTH: The question here has to do, as Jesse put it, with the amount of money in the system. We will address later on whether it's maldistributed or not.

MR. SMITH: But looking at margin by facility and concluding that the modal margin with Jack's even distribution is 3.8 doesn't tell you -- it's not talking about money. It's talking about the distribution of margin by facility.

DR. ROSS: But, David, that's not true. The pictures are different. The 3.8 is a revenue-weighted number. That's dollars in the system. The pictures are facility-weighted.

MR. SMITH: The pictures are facility, okay. That's what I was looking for. Thanks.

MR. MULLER: Just one brief question. There's a 0.5 for both '01 and '02 assumption of cost reduction as a

result of length of stay reductions in that estimate; is that correct?

MR. KERNS: There was a small reduction two the market basket increase in costs.

DR. NEWHOUSE: 0.5 for each 1 percent decline in length of stay.

MR. KERNS: And it was about 1 percent decline in length of stay, thankfully. I just don't have the spread sheet here with me, so I'm not absolutely certain of that, but theoretically that's what we did.

That was how we trended forward inpatient. Inpatient is about 70 percent of the costs and 75 percent of the payments. That made a difference of a few tenths of a point. At the end of the day, if we gave them full market basket, the margin might be a 3.7. It's not going to move it very much.

MR. HACKBARTH: I think we're ready to move to the next step here.

MR. LISK: I'm going to discuss the next section in the chapter, the base rate differential for inpatient payments.

In Medicare's inpatient PPS, the base payment rate

for hospitals in large urban areas -- that's metropolitan areas with over 1 million population -- is set 1.6 percent above the payment rate for other hospitals, those in urban, other urban, and rural areas.

Now this current payment differential is the result of policy decisions that were made over a decade ago when the inpatient PPS was first established. Rural hospitals had base payment rates that were 20 percent below those for urban. For urban hospitals, there was no distinction between large urban and other urban. Urban hospitals were all grouped together.

This initial differential was set to reflect differences between urban and rural costs not picked up by doctors including in the payment system at that time. Further analysis, though, showed that that differential was too large.

Starting in 1988, the Congress made separate updates for large urban, other urban, and rural hospitals, effectively creating three separate payment rates, while also substantially reducing differential and base payment rates for rural hospitals between large urban and urban hospitals.

Large urban hospitals received higher updates at the time because the analysis showed that the higher costs of hospitals located in large urban areas were not fully recognized by the prospective payment system at that time.

In 1990, the base rate for rural hospitals was 7 percent higher than that for other urban. The large urban rate was 1.6 percent higher than for other urban hospitals. Congress, at that time though, also decided to eliminate the differential between rural hospitals and other urban hospitals, keeping that 1.6 percent differential between large urban and other hospitals at that point in time. So by 1995, the rural differential was eliminated from the payment rate.

That's the basic history of where we are today. That initial 1.6 percent differential was based on analysis that showed that large urban hospitals costs were higher than the other hospitals.

The capital payment rate has also though -- what I want to inform you about -- there's a 3 percent adjustment in the capital payment rate for large urban hospitals.

If we look at the margin data that Jesse just showed, and this is the data if we take out the DSH payments

and IME payments, this is the core base rate margin data, I guess we might call it. Large urban hospital's margins are about 4 percentage points higher than other urban and rural facilities. So this lends some credence to the question about whether the base rates are appropriate in terms of the current differential. So about half this differential can be attributed to the current base rate differential, in terms of the differential in these margins.

Our further analysis that we have also does not support the current differential. Regression analysis we did on 1997 data, and that's because of the data that we had available and ready to be able to do this and that we used before, shows no significant difference in costs between large urban and all other hospitals, all other hospitals being the group of hospitals we are concerned about in terms of the other rate here. There's no statistical significant difference here. Basically, their costs are the same from the analysis.

If we look at more specifically the rural hospitals, rural hospital costs are likely similar to large urban hospitals in 1999. Our regression analysis for 1997, though, did show that rural hospitals costs were lower than

large urban hospitals, about 2 percentage points lower in 1997. But between 1997 and 1999, cost growth for rural hospitals was 2 percentage points more than large urban hospitals, and that's information we actually have.

So given those factors, their cost should be roughly about equal in 1999. Now we can't account for it because we don't have the data to the present time. Cost growth for rural hospitals may, in fact, even have been higher. But this data leads us potentially to the conclusion for you to make that the differential may not be warranted under the current payment system.

MR. MULLER: Do you have the numbers on Medicare margin or just on Medicare inpatient?

MR. LISK: Yes, this is the inpatient margin. The overall margin, the differential is still 4 percentage points.

MR. MULLER: Overall Medicare?

MR. LISK: Yes. That's excluding these numbers. And then there's larger differences if you put back the DSH and the above-cost IME payments.

So that leads us to the draft recommendation we had proposed in the report, that the Congress should

gradually eliminate the differential in inpatient rates between hospitals in large urban and other areas.

MR. HACKBARTH: So the line of reasoning here is that historically the differential was put into law because empirically there was a difference in the cost. Over time that difference has disappeared, therefore there should not be a differential in the base rates.

MR. LISK: Correct.

MR. HACKBARTH: Comments?

MR. FEEZOR: Based on any precedents that we have recommended, do we try to suggest a time frame on that? It says gradually. Over what period of time do we interpret gradually to mean?

MR. LISK: I think if you approve this Jack will be getting into that some in his discussion.

MR. HACKBARTH: Just as a matter of process, what I'd like to do is not vote on this particular recommendation now but proceed through the next section.

MS. BURKE: Glenn, can I just add, this is just a language issue. I noticed this earlier and I noticed it here and there may be history here that I don't understand. Is there a particular reason that we have to keep

referencing IME payments above costs? I mean, IME payments are IME payments, whether they are or aren't above costs.

MR. LISK: Yes, in terms of how we're talking about the IME payments that are directly related to the cost relationship between costs and Medicare payments. So we're putting that as though that's still in the base payment.

The IME payments, though, that are above the empirical level, the subsidy is what we're referring to there. So the IME payments above costs, we're just trying to avoid using the word subsidy.

MR. MULLER: But you clarified this morning, it's above the cost of teaching, not above the cost of IME. Because you use it as residual teaching, because you didn't put in the other kind of IME costs. There are costs to being standby, and all that other stuff.

MR. LISK: Those costs though, in how we do it though, are actually still factored in to what we say is the empirical level, though. Those costs are captured by the adjustment.

MR. HACKBARTH: So historically what we did was to examine the relationship between teaching and the costs, all types of costs, and found that those that had more teaching

had a higher cost of all type. The empirical adjustment was at one level. The factor written into law was basically twice that empirical level.

And so when Craig uses the term IME above cost, he's talking about the second half of that, the piece above the empirical relationship.

MR. MULLER: But I thought this morning in the discussion you were doing this off -- this may be too technical but if we're going to start using these words -- it was the costs of teaching that you had in your regression; correct? And the other costs historically associated with IME you don't --

MR. LISK: It's residents per bed.

DR. REISCHAUER: It's residents per bed.

MR. HACKBARTH: And the other variable is all costs of care.

MR. LISK: Medicare costs. But the other factor to consider is that when you think about the costs of teaching, if you're talking about the direct costs, those are excluded from this calculation.

MR. MULLER: No, we're talking about the other costs for which the IME adjustment was intended.

MR. LISK: That's being picked up, so everything above the empirical level is more than that.

MR. HACKBARTH: So for example, Ralph, I think you mentioned standby capacity. That would be included as a cost of care.

MR. LISK: If they have higher standby capacity it raises their cost of care, that's going to be reflected in the empirical level; correct.

DR. LOOP: Currently non-allowable costs are picked up in that? That's not true.

MR. HACKBARTH: Not non-allowable costs.

DR. LOOP: Some standby is non-allowable.

MR. HACKBARTH: I'm in over my head on that.

DR. LOOP: I think. And teaching hospitals have more non-allowable costs than non-teaching hospitals. I'm not arguing about non-allowability. I'm arguing whether that's really picked up.

MR. ASHBY: Just wanted to clarify though that there's nothing in the rules of allowability that has to do with standby costs. So if maintaining excess capacity raises your costs, by all means that is captured by the measure.

MR. HACKBARTH: Okay. Are you finished, Craig?

MR. LISK: Yes.

MR. ASHBY: If you agree with the conclusion that came at the end of Jesse's presentation, that overall payments are adequate, then under our new updating approach we, of course, have no adjustment for payment adequacy. And in the update we account solely for the cost changes in the coming year as measured by CMS' forecast of the hospital market basket.

Now in our traditional updating framework, we considered the cost increasing effects of technological advances and we expected small cost-reducing effects from productivity improvements. But as we've said before, lacking ability to measure either very accurately, we are proposing to assume that the two offset each other. And that comment, of course, can be made across any of our health care sectors.

But specific to the inpatient sector, in each of the last five years we have had a downward adjustment in the update to account for the effects of past unbundling, unbundling being defined here as services being shifted out to various post-acute care settings as the length of stay

for inpatient stays decline.

Under our new system, though, we are implicitly accounting for the effects of unbundling as we assess the adequacy of current payments, along with the effects of a host of other factors that may have paid a role in determining the adequacy of today's payments. That could include things like market basket forecast error, productivity changes, upcoding, regulatory changes, and so forth.

In theory, though, we could adjust for unbundling prospectively if we thought that length of stay will fall again in fiscal year 2003. Given that Medicare length of stay did decline nine years in a row through '99 and our preliminary data suggests that it dropped again in both 2000 and 2001, there might be some reason to think that it, in fact, might happen again.

But we note that the length of stay declines have been getting smaller. Our more recent observations are based on rather small samples. And of course we don't, as yet, know anything about 2002. So we think that it would be more prudent to basically wait and see what happens and take the result of any further declines in length of stay into

account in assessing payment adequacy the next time around. A prediction here would be rather dicey.

So that leaves us with an update equal to market basket. What we would like to propose is that we consider a set of policy changes that will increase aggregate payments by market basket but would make two simultaneous distributional changes, the first being to take the first step in phasing out the differential and base rates, as Craig was just discussing. And the second being to provide the funds needed to implement the rural recommendations that we made last spring. Those recommendations, of course, very much still stand. We'll take a look at each of those two changes in the next couple of overheads.

First, the differential. The legislated update is market basket minus 0.55 percent for all hospitals covered by the inpatient PPS. One way that we might structure the first step in eliminating the differential in base rates is by raising the update to market basket even for other urban and rural hospitals, and then leaving the legislated update of market basket minus 0.55 in place for large urban areas. That way we're not taking away from what the large urban group would be expecting under a law that's been in place

for the last couple of years.

That really speaks to the point that Sheila brought up at the last meeting, of how difficult and potentially contentious it is to implement these distributional changes. This is, I think, as easy a way to do it as there could be.

Now this change would cut the differential by about a third. We in theory could make a formal recommendation that suggests a three-year phase-out of the differential, but we thought that perhaps it would be wiser to not make such a formal recommendation but rather wait until next year when we will have at least one and perhaps two years of additional data to assess where we are before we then make a recommendation on an appropriate second step.

Then looking back briefly at our rural recommendations, the first two recommendations that we made, the first two proposed payment increases for rural hospitals, would require new money. The first and main one was raising the cap on disproportionate share add-on for most rural hospitals from 5.25 percent to 10 percent. The second was implementing a low volume adjustment.

The third recommendation that you see here,

removing select labor categories from the wage index, would be implemented budget neutral. But we included it in our estimates because it would affect the distribution of payments between urban and rural hospitals.

The fourth recommendation, which you don't see listed here, that dealt with the labor share used in the wage index. That cannot be quantified at this point in time because it depends on the outcome of a CMS study that we did recommend. But that one, too, would be done budget neutral and so does not have an impact on the level of payments as we're discussing today.

So in the next overhead, we show our estimates of the impact of these three recommendations. As you see, it ranges from a 0.1 reduction for hospitals in large urban areas to a 1.8 percent increase for rural hospitals.

Certainly this represents a fair amount of coincidence, but if you take the three impacts that you see here, combine them with the differential update that we covered a moment ago, it does on a weighted basis add up to an aggregate increase of payments of market basket even rounded to the nearest tenth percent. That was sort of convenient and it really was coincidental. Obviously, we

were not taking any of this into account last spring when we developed these rural recommendations but it does work out that way.

DR. ROWE: What's the market basket?

MR. ASHBY: 2.9 percent is the latest CMS forecast.

Let's move on to the outpatient update then.

MR. HACKBARTH: We may have some discussion of that.

MR. ASHBY: Okay.

DR. ROWE: I just want to get to Allen's point, the question about the timing. This seems perfectly reasonable to me, I'm supportive of all of this. Based on the way this works and the experience and everything else, do we have any sense that it's better if you're phasing something like this out to do it over a longer period of time, a shorter period of time, to front load it, back load it? I mean, how does it work? What's the best way to do this?

DR. REISCHAUER: I was going to say that I thought Jack said that we weren't making a recommendation, in a sense, to phase it out completely or we weren't effectuating

that. We were just going to do something that would reduce it by a third.

DR. ROWE: We're taking a third out the first bite. I guess my question is does that seem like a reasonable -- is that the way to do it?

DR. NEWHOUSE: Do you think you'd want to take out more or less?

DR. ROWE: I'm just asking. I'm agnostic. I'm just wondering how it usually works.

DR. REISCHAUER: I think Jack's point is the right one, which is you don't want to surprise large urban hospitals by cutting their payments below what they had been anticipating. And it just sort of happens to work out well this way.

DR. ROWE: I understand.

MR. ASHBY: The other point that I think shouldn't be forgotten here is this all does add up to an aggregate increase in payments of market basket, which is what we say is associated with our finding that payments are adequate. If we put two-thirds of the -- getting two-thirds of the job done here, then we would exceed the aggregate increase.

DR. NEWHOUSE: But I think the general answer to

Jack's question about how fast is governed by how big the redistributional impact is and therefore how much you have to protect people.

DR. ROWE: This sounds perfectly reasonable.

DR. LOOP: I'm not quite sure I understand why we're doing this. The rurals are about half of all hospitals. And it's a big mix of hospitals, big, small. Some of them are highly profitable and some are very poor. I'm not sure we know the unintended consequences here of taking money away from the urbans and giving it to the rurals.

MS. BURKE: But I think this scenario --

DR. REISCHAUER: Yes, relative to current law, you aren't taking money away from the large urban. You're giving them what the current law says, but our overall recommendation is that the aggregate update be higher than current law calls for. And we're saying where's that extra going to go? And it's going to go to the rurals and the other urbans.

MR. HACKBARTH: And we do know that on average those two categories have significantly lower margins. Now within those categories there's variation. But that's a

problem we're always plagued with. We've got these broad policy categories and the real world is more complicated.

MR. MULLER: I want to just confirm the answer to that I think maybe Craig gave before. The overall Medicare margin is still a four point spread between the categories of large urban versus other urban and rural once you take the DSH and the IME half out. So in a sense, the differential goes beyond just the DSH and IME policy.

MR. ASHBY: That's right. I think that's the key point. Even putting the DSH and the IME aside and dealing with them as subsidies, when you look only at payments for Medicare services there still is this four percentage point differential. The reason for that would be elusive, given that there are not cost effects.

MR. HACKBARTH: Part of it's related to the fact that there's a base rate differential.

MR. ASHBY: Exactly.

MR. HACKBARTH: We're saying there's no basis any longer for that.

MR. ASHBY: But I mean the justification for it would seem to be elusive, particularly given that there are not cost differences between these groups.

DR. ROWE: But even after you correct for this, there's still an extra 2.5 percent.

MR. ASHBY: Right. But if we're looking for symmetry, I'll offer the possibility of some symmetry coming down the line. And that is that we have a fix to the wage index that's already to be implemented. I think it will probably happen in 2005. And that will likely eliminate the additional differential that you see. There's about two percentage points left.

Most likely, that will disappear when the mix adjustment goes into effect. From what little we know from past analysis, it's about those proportions.

MR. HACKBARTH: Sheila, did you get your point in earlier?

MS. BURKE: Yes.

MR. HACKBARTH: Any other comments? Ready to move on to outpatient then? Just so people don't get lost in the conversation, we do have a series of recommendations that we will come back to and vote on one by one. We wanted to get all the pieces on the table first.

DR. WORZALA: Good afternoon. Let me start my discussion by giving you an idea of the magnitude of

outpatient spending. Spending on the outpatient PPS is projected to be $19 billion in calendar year 2003. So each percentage point change in the base payment would change payments by about $190 million. That's to just give you an order of magnitude.

As requested at the last meeting, here are the margins for hospital outpatient services. As you can see, all hospitals report large negative outpatient margins. However, these margins are difficult to use a measure of financial performance. We suspect that hospital accounting practices resulted in considerable shifting of costs to the outpatient sector because it was, until recently, paid on a cost basis. This is one of the reason we moved to looking at overall Medicare margins rather than sector-by-sector margins.

In addition, previous payment policy paid only a percentage of costs, making a positive outpatient margin impossible.

For these reasons, we tend to look at outpatient margins for assessing differences across groups rather than to determine absolute financial performance.

That said, we can see that the estimated margins

in 2002 show an improvement over 1999 under the assumptions that we have made. This is due primarily to the transitional corridor payments that added new money to the outpatient sector. As you can see, rural hospitals benefit disproportionately from the corridors due to their hold harmless status with a significant improvement in their average margin.

The modeling included only the impact of corridor payments to be received in 2003. So these margins do not include other new sources of money received during 2000 and 2001 and 2002. The reason we did it that way is because these are additional payments that would not affect the base and since our update decision is concerning the base payment rate we did not include additional payments that weren't built into the base.

And here we're talking about the transitional corridor payments and also extra payments received due to implementation of the pass through in a fashion that was not budget neutral. So both of those things would have increased payments in the intervening years but are not modeled in these margins. So I think we can say that these margins in some ways despite their very negative numbers,

understate financial performance.

This slide lays out the factors we considered in making the update recommendation that you will consider. Given that we concluded payments to hospitals are adequate as a first step, we make no adjustment to the update for payment adequacy.

Then, consistent with our analytic approach, we use the expected change in input prices as measured by the hospital market basket as our base. We then consider the extent to which other factors are likely to make a significant and measurable difference in costs or payments.

In the outpatient sector the cost of technological advances are accounted for directly, both by the new technology APCs and the pass through payments. The new technology APCs result in new money for each service provided and do not therefore need to be taken into account in the update.

The pass through payments, however, are meant to be budget neutral. Assuming that budget neutrality will be maintained in 2003, these costs should be considered in the update process. However, we have very limited ability to forecast these costs. Therefore, as we've done sort of

across sectors, we assume that cost increases due to technology are approximately balanced off by increases in productivity.

However, we think this is a conservative assumption for outpatient services that is likely to go to the benefit of hospitals. This is both because many technological advances will come in through the new technology APCs and also because both CMS and industry sources predict a limited number of pass through technologies to be approved in the coming years. Therefore, the new technology costs may actually be less than what the productivity improvements would be. However, again, we have very little information to quantify that so we chose not to.

Finally, we considered the effect of implementing a new payment system. The outpatient PPS was put in place in August 2000 and, of course, hospitals incurred some cost to revise billing and information systems, train staff, and adapt to the new payment system. Most of these costs should be absorbed by 2003 however.

On the other hand, the new payment system may provide hospitals with both a tool and an incentive to exert better cost control. Implementation of the inpatient PPS

showed that hospitals tend to rein in costs in response to prospective payment and the uncertainty of a new payment system. Again, we can't quantify these things so we make no assumption.

A final issue to consider in regard to implementing a new payment system is the effect of improved coding on payment. The outpatient PPS provides hospitals with an incentive to code correctly. We may therefore find payments increasing in the first years of the system due to an increase in the reported case-mix that is due more to coding improvements than to changes in the services that are provided. So they're not actual case-mix changes, it's just reported case-mix changes.

We would think that this would lead to payments being greater than costs, but again we can't estimate the net impact. So that's something that we'll want to try and measure in the future but at this point in time we make no assumptions on the point.

So after looking at all these factors we concluded that market basket is the appropriate update recommendation for the outpatient PPS and, as it turns out, this conclusion is consistent with current law which gives the Secretary the

authority to set the update based on the market basket, barring additional legislation.

I have drafted two recommendation options for your consideration and they are mutually exclusive. The first one simply states our conclusion and directs the Secretary to update outpatient payments based on the market basket. The second one acknowledges that this is consistent with current law and states that the updates and current law is adequate. It's simply a wording difference and one or the other recommendation is sufficient.

MR. HACKBARTH: Do you want to comment, or, Murray, do you want to comment on the relative merits of the two approaches? Why did you see fit to offer an option here? I was expecting one along the lines of the first.

DR. WORZALA: The first is our process and it's our conclusion, but I think previously we've been hesitant to make a recommendation that says do what's in law. Sort of like saying obey the speed limit or something like that. I think it's purely up to you. We certainly did follow a process. We didn't start with current law as the objective and shoot for that target. We followed our process and it came to that conclusion. So I think it's completely up to

you.

MR. HACKBARTH: So as I understood what you said, Chantal, in several different instances we made assumptions that were favorable to hospitals in the absence of information, recognizing that under our payment adequacy approach if in the future we find that payments are high relative to costs we can make a recommendation at that point to compensate for any overpayment.

DR. WORZALA: Yes, I think that's the idea.

MR. MULLER: Just a question. But in terms of the payment adequacy framework that we've been adopting the last few months we're saying, even though on the face of it the payments aren't adequate by being minus 17, we're using the inpatient margins being higher as a kind of way of saying therefore it's okay to have inadequate outpatient rates?

MR. HACKBARTH: What I understood was in fact we think those numbers are skewed, they're an artifact of accounting and they're not the real economic profitability or unprofitability of outpatient services.

MR. MULLER: I don't think anybody's arguing there's a 17 percent skewing. Are we arguing that?

MR. HACKBARTH: Actually, I think people are

arguing that, just that. Does a staff member want to address that?

DR. REISCHAUER: Presumably, if we're mismeasuring on one side, underestimating, we're overestimating on the other. And so that's why we look at total Medicare margins and we say well, they're 3.8 so on the whole we shouldn't lose sleep tonight.

MR. MULLER: I agree with the way you posed it, but that's different than saying there's a 17 percent skewing on cost reporting.

MR. ASHBY: But, Ralph, the only evidence we have suggests that there is a skewing on cost reporting of about those proportions. Now granted, the study is 10 years old, but I'm not sure that the world has changed dramatically from a cost accounting view. But the finding was at that point that the outpatient costs were -- the actual raise was 15 to 20 percent overstated, which would leave the inpatient rate at about 4 percent or so understated.

DR. ROWE: I think one other consideration here is that -- I'm not sure I completely agree with Bob about the fact that that's why we look at total. And what you lose on the peanuts you make on the potato chips. There's some

accounting -- funds are being moved around, costs are being moved around here. So we take care of that by -- I think that's right and reasonable.

But we should at least all be aware that there is a lot of variability across institutions and a lot of individual hospitals have very little outpatient and other hospitals tend to have very large outpatient, particularly in rural areas or in urban areas of underprivileged populations, underserved populations where there aren't as many practitioners in the community.

If you go to Harlem, there are very few doctors working in the community and more care tends to be delivered in outpatient departments of hospitals, et cetera, et cetera. So I think there are these differences.

DR. NEWHOUSE: But if you have a bigger outpatient department you can shift more of your costs there. If you don't have an outpatient department you won't have cost shifting.

DR. ROSS: Just briefly, to address Ralph's point. I wouldn't phrase it quite that way, that we say it's okay to observe these large differentials, even stipulating to the amount of cost allocation that may have occurred. But

we don't yet have a strong case to make on exactly how would we correct it for any underlying differences? We don't want to dramatically underpay for a particular service because of variations across facilities. And we don't want to dramatically overpay for other services. But we don't have the evidence to suggest any precise kind of adjustments.

MR. MULLER: But I think that's the argument -- whether one uses Jack's metaphor or somebody else's -- that the inpatient margins cover a minus 17 and outpatient is one, that people roughly come to some rough sense of justice about.

If on the other hand, in one of the prior pages, we're looking at starting to make differential adjustments in inpatient recommendations because "they're a little higher" then that starts affecting how one things about the balance with outpatient. We're using those higher inpatient margins, in a sense, to cover the lower outpatient programs.

MR. HACKBARTH: The previous discussion was based on overall Medicare margins and differences between large urbans and other urbans and rurals, not just the inpatient. Just to be clear about that.

So it's not a case where we're looking at the high

inpatient margin of a large urban and ignoring their loss on outpatient and saying there should be redistribution based on the inpatient margin. We looked at the overall margins and saw that they were significantly higher and that there was no basis empirically for a differential and said we ought to start to eliminate.

Questions or comments? Okay, let's proceed to voting on the recommendations then.

Actually while I'm thinking of it, we do have the two options for the outpatient. Option one, I think, is the one we will vote on, the more straightforward language.

So our first draft recommendation is on the gradual elimination of the differential in inpatient rates.

All opposed?

All in favor?

Abstain?

On this recommendation, all opposed?

All in favor?

Abstain?

And on outpatient, all opposed?

All in favor?

Abstain?

Okay, thank you. I think what we'll do is proceed to discuss paying for new technology in the outpatient PPS. Welcome back, Chantal. We missed you, you were gone so long.

DR. WORZALA: Dan and I are here to discuss how Medicare pays for new technology in the outpatient setting. I'm going to very briefly summarize the issues, which we've presented before. Dan will then discuss how we propose to address those issues and present a draft recommendation for your consideration.

Medicare has an obligation to ensure beneficiary access to needed new technology by paying adequately for it. However, it's difficult to set payment rates for new technology because there is very little data available to determine costs. And the two basic payment approaches we use, bundled payment and cost-based payment, are both inadequate. A bundled payment has the potential to limit diffusion of new technology by underpaying for it at the margin. However, a cost-based payment has the potential to increase use of technology unnecessarily, leading to excess spending and possibly inappropriate use.

This is a problem for Medicare in all of its

payment systems and, as we discussed at the last meeting, it's also a problem that can be extended beyond new technologies to those for which Medicare is the only or the major purchaser. However, we propose to address only the treatment of this issue in the outpatient PPS at this time. We recognize that the Commission may wish to explore the issue and extend it to other areas in the future.

The outpatient PPS tried to address the issue of how to pay for new technology inputs by implementing the pass through payments which are meant to cover the incremental costs of new technologies when they are used. However, the payment mechanisms that are used have the potential to lead to overpayments. By paying hospitals charges reduced to costs for medical devices, the system provides incentives for manufacturers and hospitals to increase their prices and charges. And by paying 95 percent of average wholesale price for drugs and biologicals, Medicare generally pays more than hospitals' acquisition costs for these products.

Overstated charges will also lead to distortion of relative weights when the costs of pass through items are incorporated into base payments. Services using pass

through items will be relatively overpaid while other services will be relatively underpaid.

At the last meeting we presented three options to address these issues. Taking into account your discussion of those options and comments by others, Dan will now present our thoughts on how to address them.

DR. ZABINSKI: After considering the commissioners' comments on the options we presented at the December meeting, Chantal and I have concluded that the best course of action is to base pass through payments on national payment rates. For devices, this would include a fee schedule with national rates which would replace the current hospital-specific payments. For drugs, the Secretary should be allowed to base payments on alternatives to average wholesale price or AWP.

Using national rates like this would reduce the potential to overpay for pass through technology. This is because the fee schedule would eliminate hospitals' incentive to raise charges for devices which is present under the current mechanism. Also, the Secretary would have the opportunity to base pass through payments for drugs on alternatives to AWP that better reflect what hospitals

actually pay for drugs.

An issue we emphasized that Chantal touched on earlier is that good data for setting fee schedule rates are very difficult to come by. After all, one of the reasons that the pass through system exists is because CMS did not have adequate cost data on new technology to incorporate them into the APC base payment rates.

Chantal and I, as well as others on the MedPAC staff, have considered several possibilities for setting rates. We believe the best option is to use manufacturer's estimates of how much hospitals will pay for new technology net of any discounts or other reductions. This information could be used in place of AWP for drugs, as well as in a fee schedule for devices.

We recognize that this would give manufacturers an incentive to inflate reported costs, and there's nothing in the pass through system that would dampen this incentive. For example, if the pass through technology had to pass a cost benefit test, then there would be less incentive to inflate reported costs. But no such criterion exists in the pass through system.

However, CMS could audit the cost estimates for

manufacturers to reduce this problem. Furthermore, this option does have some advantages. First, there would be little additional burden on CMS because manufacturers are already required to include this information on applications for pass through eligibility.

Second, hospitals would have no incentive to inflate charges, which they have under the current mechanism. Therefore, CMS would have better data when it folds the costs of new technologies into the base payment rates after pass through eligibility is used up.

Finally, this option would introduce consistency with how pass through payments are determined for inpatient care, which have an upper limit on the prices paid by hospitals as reported by manufacturers.

Finally, we have drafted this recommendation that reflects our analysis of the issues in the pass through system and the issues that the commissioners have raised at previous meetings. In particularly, we believe that Congress should replace hospital-specific payments for pass through devices with national rates to be set by the Secretary. Also, the Congress should give the Secretary authority to consider alternatives to average wholesale

price when determining payments through pass through drugs and biologicals. That's it.

DR. NEWHOUSE: I am reluctant to accept that this is the best option. Essentially the argument is that -- first of all, we're going from cost-plus basically to cost. The whole thrust of policy here in the last 20 years has been to try to get rid of cost reimbursement. And for us to now recommend that here is very hard for me to swallow.

I suggest the following modification. It seems to me where the problem with having this in the APC is the greatest is where, first of all, there's a substantial dollar amount for the drug or device. So that if the payment for the APC is $500 and this piece of technology costs $500 it's going to be hard to get it in. If it costs $15 it's probably not a big deal.

And secondly, where the Medicare market share for this product is high, if it's not high then CMS can observe what's going on in the private market and just pay that.

So I think rather than pay cost it would be better to say leave it in the APC. If you want to, put an S&TA in the APC to cover this, just like we do in the PPS. Except when the dollar amount is above X and the share is above Y.

Now what X and Y are, I don't think I'd want to say now without seeing some distributions.

And then, in those cases, I think I would try to set the fee based on some return to equity for that product. But the intent would be to try to minimize the number of cases when I have to do that.

MS. BURKE: Joe, don't you create the incentive to go to X?

DR. NEWHOUSE: Don't you what?

MS. BURKE: First of all, I don't disagree with your premise, but A, I wonder how complicated we can expect a relatively unsophisticated system to get in payment. But B, a model that has you setting an X and a Y just assumes everybody is going to move to X if they can.

DR. NEWHOUSE: Depends on, particularly if I don't model the -- I'm not sure it does. I'm thinking of devices that are pretty specific to the elderly, or drugs. In Medicare erythropoietin would be the extreme case. If I have a device, a disposable of some sort, that's probably not very elderly specific and I'm probably not going to take it off the non-elderly market just to get to X.

MS. BURKE: So in that case you'd go to the

market, I understand. It's the non-market base that when there's not another market, when you're essentially creating a market and essentially setting anything above -- it's the old if it was below $50 million it was a rounding error. We used to star it. It was like well, what's the number? The number is $15. Okay, well I'm at $13.50, I'm going to move to $15.

In setting the market if you set an arbitrary number, it seems to me, you create an incentive for people to move --

DR. NEWHOUSE: That's why I'd want to look at the distribution. You may get some gaming in the neighborhood of X. But the alternative, to me, is even worse. Then why don't I just mark up my price a whole lot and take it to the bank?

MR. HACKBARTH: I'm going to need to go back for a second because I think I'm confused. The option that's been recommended by the staff is manufacturer's estimates of what a hospital is paying net of discounts. I assume that's private patients as well as Medicare patients. So it's what hospitals have been paying for these devices regardless of whether it's going into a Medicare patient or a private

patient, right?

DR. NEWHOUSE: That was true when we had cost reimbursement for all hospital costs.

MR. HACKBARTH: So where there's an active private market, those rates that they pay may be influenced by pressures from managed care, hospitals who are saying we can't afford to pay a lot for this device because we're not getting a lot from the health plan. So there's some market pressure to hold those rates down.

And you're worried not about that case, Joe, but about the case where these are pretty specific to Medicare beneficiaries and there's not much market pressure?

DR. NEWHOUSE: That's right. But upstream of that I'm worried about -- we probably first ought to decide whether we want to pay on the basis of cost. Maybe you can't decide that without saying what is the option that you're going to pay under.

MR. HACKBARTH: What gets us into this conversation, as I understand it, is we don't have any data. And so we're grasping for something to hang our numbers on and something that can be administered, as opposed to the hospital-specific charge-to-cost rations, the staff is

suggesting let's look at what was actually paid.

I don't think with any pretense that it's perfect, but perhaps better than the cost-to-charge ratio.

MR. MULLER: I understand, Joe, to use the analogy to the inpatient program, which I think you made, and using your X and Y categories, you're basically trying to reduce the number of exceptions so it becomes more of an outlier policy in the inpatient program. In part, because I'm also assuming that under the current law that it's all budget neutral, then in that sense having fewer exceptions is what you're looking at here.

DR. NEWHOUSE: Yes. The other difference with the inpatient side, as has been brought out in the earlier discussions, was frequently these kind of costs are going to be larger relative to the payment for the category than they are on the inpatient side, so the deterrent to not put it in there will be correspondingly greater.

MR. HACKBARTH: So, Joe, are you suggesting that for the devices that are used by private patients as well as Medicare that there not be any pass through at all? That they be immediately incorporated in APC rates?

DR. NEWHOUSE: Yes, or that we do what we do on

the inpatient side which we've put an add on into the APC rates for something that's called new technology. But that's just global because we can observe a price there, or we will shortly, and that's about what we should pay.

MS. BURKE: But, Joe, arguably the difference between the inpatient and the outpatient is what it is, which is on the inpatient side you have a much bigger buffer. But on the outpatient side you're going to have a far narrower buffer. So that incorporating it in a general way into the raid may still leave such a disincentive for the incorporation of the new technology in the short term as to be at odds --

DR. NEWHOUSE: That's why this quasi-outlier scheme needs to be quite a bit bigger, I think, than it would be on the inpatient side.

DR. WORZALA: On the issue, I don't know what we could do about Medicare share. I guess we could ask manufacturers to tell us what they expect the market to be.

On the issue of a dollar, we did sort of talk a fair amount about setting a dollar threshold. And if I can direct your attention to our briefing papers, there's a text box on eligibility for pass through status that begins on

the bottom of page seven and continues on page eight. The clinical criteria for a pass through item on the outpatient side have been tightened considerably in a final rule issued, I believe November 2nd of last year. That is described on page eight.

On page nine, all the way at the bottom are the cost criteria. What are currently in place by CMS are all relative cost criteria. There is no actual dollar amount threshold. We did contemplate whether or not we would want to introduce the notion of a dollar amount threshold, but we had this problem that Sheila raised of well, once you state a cost how about that, everything costs that or more.

And then there was this issue of how do you actually update it over time? I expect you can collectively think of ways around those and we would certainly be willing to hear it.

But let me just clarify what the existing cost criteria are. Again, these are all relative. The first is that the average cost -- and again we're talking about categories here, this becomes nothing but more and more complicated. This is on the device side and we have categories of devices, so it's not a single item but it's

multiple items that serve the same purpose.

So the estimated average reasonable cost of devices in the category must exceed 25 percent of the payment amount in the applicable APC. So it has to represent at least a quarter of the total estimated cost.

And then the estimated average reasonable cost of devices in a category must exceed the cost of the device it replaces by at least 25 percent. So new technology is 25 percent more expensive than old technology.

And then the final is that that 25 percent difference represent at least 10 percent of the base payment rate.

So it is true, for example at the moment we have catheters as something eligible for pass through payments, just regular catheters used during surgery, implemented and taken out. That is a relatively low cost item where you can actually have a lot of things coming through and they probably shouldn't be coming through the pass through. But given the revised clinical criteria, I doubt that that sort of thing will be coming up for eligibility in the future. And it's likely -- I can't say this for sure -- but given these relative criteria it's likely that mostly only very

expensive items will go through.

And again I actually do have a hip pocket slide that is a recommendation that says put in place a dollar amount threshold. We can certainly go down that road but I wanted to let you know both what the current criteria are in terms of cost and also some of the issues surrounding introducing that.

DR. NEWHOUSE: May I respond to this? First, on how to estimate the share. I would actually I think have a panel of MDs say to what degree is this device going to a disease or diseases of the elderly. You're going to make some mistakes, but as a rough cut you'll probably get it where it's basically mostly elderly.

On Sheila's issue, which you also raised, of if I set a dollar threshold I raise it so everything is at the threshold. I think that applies to the share, as well. So I don't see that the share gains.

On increasing it over time, I would in fact index it to probably the GDP deflator, but you can put in some kind of indexing on a dollar amount.

DR. ROWE: I thought I understood this, but the more we discuss it the less clear I am. Let me just make

sure that I got this wrong, because I want to make sure I got this wrong.

If I am a person who makes a device that is of particular use for the elderly and relevant to a certain APC, and the APC cost is $400, and my device costs $50, the hospital has to eat it. But if I increase the price of my device to $125 then it's a pass-through. The hospital doesn't have to eat it and I get paid directly by Medicare. Is that right?

DR. ZABINSKI: The hospital pays you, the device manufacturer. The hospital gets an increased payment.

DR. ROWE: But Medicare is paying more, the incentive is to increase the thing so that it gets to the pass-through. I'm wrong in as much as I don't get the check from Medicare, I still get the check from the hospital. But I'm right --

MR. MULLER: The check goes to the device, it doesn't go to you. I mean, you countersign it and move it on.

DR. ROWE: I understand, but the incentive is to dramatically increase the price to get it above the threshold for being a pass-through. It saves the hospital

money, which is fine. But increases the Medicare program's cost.

MR. MULLER: No, it doesn't because first of all, the APCs become budget neutral so they get recalculated. Maybe not in your hospital --

DR. ROWE: But I'm ripping off the system, is my point.

MR. MULLER: The $125 you pass on to the device manufacturer.

DR. ROWE: But I'm the device manufacturer.

MS. BURKE: Jack, here's the alternative. You create a device, the device costs $125. The APC is $400. We don't adjust it. It's a new device we've not seen before. The APC doesn't have it in the base calculation. And we can chose to eat it or not use it. That's the alternative.

DR. ROWE: I'm not attracted to that either, but you understand what I'm saying.

DR. NEWHOUSE: But if the device has a relatively low Medicare share, the hospital is probably going to stock it for the non-Medicare market. It will probably then filter in.

There's no good answer here. Chantal is certainly right about that. The issue is what's the least of evils.

DR. REISCHAUER: So we don't worry about that. Now what are we doing about the one that has a high Medicare share? What's your answer again?

MS. BURKE: He's going to set a price.

DR. REISCHAUER: But the price is going to be an absolute dollar level, like $75, as opposed to X percent of the APC?

DR. NEWHOUSE: Yes.

MS. BURKE: That's what he's proposing.

DR. REISCHAUER: Why shouldn't it just be X percent of the APC? It strikes me that if it's $75 --

DR. NEWHOUSE: Suppose the APC is $10,000.

DR. REISCHAUER: So it's easier to swallow $100 device in a $10,000 reimbursement than it is in a $400 reimbursement, from the standpoint of the hospital.

MS. BURKE: Then it won't meet the threshold.

DR. REISCHAUER: I'm just saying why do you need two things? I would think that what you would want to have is -- big depends in a sense or on how big it is relative to the payment the hospital is getting. That's all.

DR. ROWE: But if there's a $10,000 payment -- let's use the extreme example. And I'm still making my device, I'm now a device manufacturer. And it's $100 device but I decide to charge $2,550 for it instead of $100. It makes the pass-through, I get paid all that, and that's outrageous. And if there's a sole source and doctors really want to use it, that is what's going to happen. So we've got to avoid that somehow, Bob.

MR. DEBUSK: Manufacturers don't do that, Jack.

[Laughter.]

DR. ROWE: I withdraw my concern.

DR. REISCHAUER: There is a Defense Department toilet seat threshold, and even Pete with a straight face wouldn't charge $2,500 for this $100 device.

DR. ROWE: Then I don't have a problem. If everybody's comfortable with it, fine. I just was listening to what I was hearing and I was concerned that there was going to be this incentive to raise the prices.

MR. SMITH: Of course you're right. And Pete, with all due respect, in this closed market if you're sent a signal that X is okay, that's what you'll charge. It

doesn't seem to me that either the percentage threshold or the dollar, Joe, get us over that. We are setting a floor for a bunch of devices that we don't know about, that we don't know how much they cost, but we can tell you what the price is going to be in Medicare-dependent markets.

DR. NEWHOUSE: Remember, if you get over the threshold, HCFA sets the price. It's not your price anymore.

MR. HACKBARTH: But on what basis?

MS. BURKE: Joe's view is CMS sets the price.

DR. REISCHAUER: You get over the threshold with a $2,500 price and the HCFA comes back and says $100?

MS. BURKE: Yes, that would be about right.

[Laughter.]

DR. REISCHAUER: I don't know why you have to have the dollar value, is all I'm saying.

DR. NEWHOUSE: I'm trying to minimize the amount of price setting that's going on. You've got to meet two tests. Even if I have a 70 percent share, if it's a very small cost I'm not too worried about the incentives to adopt it. That's why I've set the dollar threshold.

But you can have one threshold, you'll just wind

up setting more prices that way.

MR. HACKBARTH: But in the case of something, Joe, that comes in under the threshold, it's got to be incorporated in the APC. You still have to have a number there, don't you?

DR. NEWHOUSE: No.

MR. HACKBARTH: You just eat it.

DR. NEWHOUSE: You just swallow it. You treat it like you do the inpatient side.

MS. BURKE: And it happens over time.

DR. NEWHOUSE: Then over time you'll get some numbers and you can feed it in.

MS. BURKE: It's the extraordinary entry that's the issue, not the routine integration. It's the extraordinary entry, a new event at a particular time that's significant enough to deter its use if, in fact, it's not accommodated. That's what Joe's concerned with. What's the outlier, is the issue? It's not the routine that we adjust for over time.

MR. SMITH: But I think Jack's imitation of Pete suggested that if there is a trigger, we're going to have more prices at that trigger. I don't think we know anything

that suggests that that isn't true.

MR. DEBUSK: And competition comes into play. Can we back up just a minute and get just a little bit more grounded. Let's go back and look how we got into this $1.7 billion over the allocated 2.5 percent of the $17.5 billion. Chantal, that was done very well, the chapter on this, in my opinion.

You know, you go back and look, we come along with BBRA, BIPA, and we try to put more dollars into a bad situation to try to make up some of these dollars to keep that hospital alive, especially with the outpatient piece. And we kept reaching back and taking devices out of what was already figured in the rates in '96, and we pulled them forward and started paying for them as if they were new technology.

And there were two or three inputs, and we just drove that cost way up. And then you know the results we got and so now we're addressing that.

I think, when all of this goes back into the APC code this fall, and we truly look at new devices going forward, it's not going to be that bad. I don't think there's that big of an issue.

Now going forward, I sort of like the comment here, pass-through devices with national rates to be set by the Secretary. Of course, there's multiple things that come into that, but they're in a far better position to go forward and decide what some of this new technology, like some of these stents that we talked about briefly last time, which is quite expensive. But this is tremendous new technology that all of us are going to want if we're requiring something of that nature, and these pacemakers and what have you.

But they will be in a lot better position to look at that, to address what Medicare should pay for that, I would think. I think this recommendation is put together pretty well.

But there's always going to be this issue that Joe's talking about here. How do you keep that target from being set up here and saying here's the target, so everybody's going to go to the target?

MR. HACKBARTH: So let me see if I can summarize what I've heard. There seems to be agreement between the industry and CMS, as I understand it, that the huge bulge of things coming through the pass-through that happened this

year isn't going to happen in the future, that we're talking about a much smaller number of devices.

CMS proposed a series of threshold requirements, cost and clinical, that Chantal reviewed just a minute ago. You're saying those thresholds are too low?

DR. NEWHOUSE: No, I said I don't know until I see a distribution. But again, let me say for the people who are worried about it going to the threshold, it depends on what the alternative is. But remember, if you're over the threshold, you get your price set. So the incentive is to stay under the threshold.

Then the issue is what were your incentives in the alternative world, where there was no threshold? It doesn't seem to me that the threshold distorts your decisionmaking.

MR. HACKBARTH: But, Joe, the way I understood your initial point was that you wanted to limit still further the number of devices that are subject to the pass-through by creating a threshold and saying we're only going to do this if it's relatively large and it's very important for Medicare.

DR. NEWHOUSE: Over time you're going to get -- you'll accumulate a stock of things that are pretty much

Medicare specific, in which case I've got the problem back to the device manufacturer of how does this thing price? It seems to me that's an open invitation to raid the treasury.

MR. HACKBARTH: But was my description accurate? You want to further limit the number of devices subject to the pass-through, saying all the small stuff is going to go straight into APC. We're going to set a high threshold to limit it.

DR. NEWHOUSE: Yes.

MR. HACKBARTH: Then in that case, when we've got those few devices left, the price we set is going to be done by what mechanism? How are we going to pull that number out of the hat?

DR. NEWHOUSE: I think I would do it as a return on equity.

MR. HACKBARTH: How are we going to know?

DR. NEWHOUSE: You would take the share of the manufacturer's total line of business that the Medicare business represents -- which may be high if I'm a startup with a single device that's mostly Medicare. And you would say I'm going to pay whatever number you pick, 15 percent, 20 percent return. I'm going to set the price to achieve

that.

MR. HACKBARTH: But how do you know what their investment was? If it's a multiproduct firm --

DR. NEWHOUSE: This is how the British run their drug price regulation and they've done it for a number of years and it seems to work, by all accounts I hear.

The alternative, it seems to me, is you ask you set any price here for the new technology. Or you just do cost, which I don't think you can do in these cases where there are costly items and there's a big Medicare share.

DR. ROWE: The second part of my concern about this had to do with migration of activities from the inpatient to the outpatient in order to try to take advantage of this pass-through. This business about endovascular procedures are now very common and stents are being used and they're now coated with antithrombotic pharmaceutical agents or antibodies, and $10,000 is not an unreasonable -- well, I don't know if it's reasonable or not but it's a common price for these items. And if it's done in the inpatient it's in the DRG and the hospital eats it and it's very expensive and very difficult. But patients clamor for it, et cetera, et cetera.

On the other hand, now if you have an ambulatory surgery facility that's sort of defined as part of the hospital and the patient comes in, these procedures, the patient has them and goes home and they don't stay overnight, it's being done now in the outpatient. Does this mean that that price now is then pushed over to Medicare and we're going to see all these cardiac caths and aortic procedures and everything all of a sudden now defined as outpatient?

I'm just trying to think -- and maybe that's right. Maybe it's okay because even if we pay $10,000 for the stent in the outpatient APC, the rest of the cost is so much lower than the inpatient cost would have been that maybe in the long run it doesn't cost more. I don't know. And what's better for the patient? I don't know.

I'm just trying to understand whether or not we're creating rules that are going to create financial rather than clinical incentives to migrate the care of our beneficiaries from one site to another. And that's not what we're about, presumably, so we should be aware of that.

MR. DEBUSK: Sometimes, Jack, maybe what we have is not broken as badly as we think it is.

MR. HACKBARTH: But in the case of a device that's used for inpatient care as well as outpatient, and the hospitals are constrained on the inpatient side, presumably the negotiation has a different flavor to it than if there's a pass-through payment.

So if, in fact, there's a big inpatient market for it, presumably they're bargaining as best they can for the lowest possible price from the manufacturer. You really only worry about the price where they can somehow pass it through and don't have to negotiate.

DR. ROWE: No, what they're doing is they're paying the price demanded by the manufacturer, and they're losing money on that case because if they don't do it their cardiologists will leave and go to another institution or that aortic surgeon, et cetera, and this is cutting edge and the patients demand it, et cetera, et cetera. That's what they're doing.

MR. MULLER: As we learned last month, just in big urban centers.

[Laughter.]

DR. ROWE: I don't know that it's a problem. Just we should think it through.

DR. WORZALA: Just on the issue of setting, a point of clarification. There is also a technology payment that will soon be in place on the inpatient side, as well. The clinical criteria for eligibility for a technology are very similar between the two, if not identical. The cost criteria are different and the payment mechanism are different.

We actually, with our recommendation, were trying to introduce a little bit of similarity across the two settings because on the inpatient side they make these additional payments based on the cost. But the payment is limited by "average national price" which will be determined by CMS. And in my conversations with CMS they say well, we'll have to take it off the application and we'll audit that information.

So part of what we're trying to do is introduce commonality across settings so that we have a national payment rate rather than a payment based on hospital cost. We can make the point more clearly. We do try to do that.

MS. BURKE: Let me understand. Is there a compelling reason for us not to use the same pricing mechanism?

DR. WORZALA: For one thing, we can't assume that the technologies will be exactly the same.

MS. BURKE: Irregardless of whether they are the same, whether they're both stents or whatever. But is there a reason not to use the same strategy?

DR. WORZALA: I think it comes down to the size of the bundle and the fact that on the outpatient side your technology may well represent a larger share of the total cost. And on the inpatient side you have a much broader --

MS. BURKE: No question.

DR. WORZALA: So that's the rationale.

MS. BURKE: But that's just an explanation for the margin of error. I mean, that's how you protect against margin of error. That isn't the fundamental question of how you determine the price.

DR. WORZALA: The price limit, I would agree, it's exactly the same. But what they're doing on the inpatient side is to take the cost of the actual case and say is that -- I may get this wrong, but bear with me on the details. It is in your briefing paper in one of the text boxes.

My recollection is that they take the cost of the case as reported. They determine whether that's greater

than one standard deviation above the geometric mean cost of case in that DRG. And then they pay half of the difference, half of the excess, up to a limit. And that limit is the average national price, which they will determine in negotiation with the manufacturers.

MS. BURKE: Let's stand back for a second and look at this. What Joe suggested -- and I'm open on what the solution to this is -- is essentially you look at it arguably as compared to something. In this case, you look at it as compared to the total case cost, which presumably is much larger than the APC. One scenario has us comparing it to the APC, which is part of one of the scenarios here.

So my thought is just if we're going to go down some road, why not at least have similar characteristics in both roads? I mean, the basis will be different. But the process, there's no particular -- that I can hear -- compelling reason not to use a similar process knowing that the basis will be different.

I mean, we know that the margin is greater on the inpatient side because you've got a bigger base. But if you do it as a comparison to the APC rate, you've got a smaller base. But the principle is the same.

MR. MULLER: I would say, the paper was very good on this. This pass-through system is way too big, the 13 versus the two. It's incredibly administratively complex in a system that's already complex and hard to understand. So trying to get the number of pass-throughs to as small a number as possible I think is an objective everybody has, so it can get back into the regular system.

So insofar as Joe's recommendation gets us there, I second it. I think trying to get the number of pass-throughs down to a low number, as opposed to the very high numbers right now, is a very appropriate thing to go for because we already have an overly complex system that's been difficult to implement.

DR. NEWHOUSE: You can get to a smaller number. The issue is once you've gotten to the smaller number, then what do you do with the group that's in the small number? So what I'm trying to do is trying to minimize the amount of price setting for that small group which will grow larger, of course, over time potentially.

MR. HACKBARTH: Let's just review where we are. That was a helpful comment, Ralph. So let me phrase this as a question. Do we have agreement that we ought to continue

a pass-through but try to make it smaller than it's been? That's where we left it last meeting. Is everybody still on board for that?

DR. NEWHOUSE: I'm not sure. If I stuff it into the APC then there's no longer a pass-through. So there's this outlier thing where there's still a pass-through of sorts.

MR. HACKBARTH: Let me phrase it in a different way. We recognize that outpatient services and devices present some different issues than inpatient because the device costs could be --

DR. NEWHOUSE: There's the same issue on inpatient.

MR. HACKBARTH: But in fact, it has been handled differently in outpatient.

DR. NEWHOUSE: Historically.

MR. HACKBARTH: So are you suggesting do away with any --

DR. NEWHOUSE: I'm with Sheila, apply the same principle.

MS. BURKE: If you're moving to a new system on the inpatient side, my only point is let's try and at least

track the theory behind both and then at one point you trigger it, what the margin is, how you fix the price. We can talk about that, but at least in principle, if we're moving to that kind of a pass-through system on the inpatient.

MR. HACKBARTH: But in both cases it involves a supplemental payment for new technology for a period of time.

MS. BURKE: Yes.

MR. HACKBARTH: So maybe we ought to avoid the language pass-through and call it a supplemental technology payment.

DR. ROWE: At a price determined by CMS.

MR. DEBUSK: Yes.

[Simultaneous discussion.]

MR. HACKBARTH: Again I'm trying to figure out where we've got agreement. So whether it's inpatient or outpatient, we're talking about a temporary supplemental payment for some new technology that tends to be very expensive new technology, the exact threshold to be defined. We want to keep it as small as possible --

DR. NEWHOUSE: With a high Medicare share.

MR. HACKBARTH: With a high Medicare share.

DR. NELSON: And a single national rate.

MR. HACKBARTH: And the question that I don't think we've been able to resolve is exactly how to set that national rate. We don't want it inflationary -- we've got to have one conversation, this is complicated enough.

So some sort of an adjustment for new technology with a set rate that is by a means that isn't inflationary. And we want to keep the class that it applies to as small as possible. That's the common ground?

DR. WAKEFIELD: Are we talking about a supplemental payment that's paid in a budget neutral fashion? Does budget neutrality come into play here?

MR. HACKBARTH: That's the current framework, is that it needs to be budget neutral.

DR. WAKEFIELD: So then do we need to be concerned about hospitals that don't have a case-mix that would be using the sort of technology if then the payment for that technology is done in a budget neutral fashion? Then are we distorting some of the payments to hospitals that have a different case-mix?

MR. HACKBARTH: It has redistributive effects.

MR. MULLER: We're trying to keep the class small.

MR. HACKBARTH: Exactly. One of the problems --

DR. WAKEFIELD: So we want to make sure that's clear.

MR. HACKBARTH: That's a reason for keeping it small. One of the reasons it was a big issue this year is because so much flowed through.

MR. DEBUSK: But that's going to be over with. That's sunsetted.

DR. ROSS: Could I just respond to that? Redistribution depends on what you think is the status quo here. If you include in these payments, yes you push resources away from institutions that don't use those new technologies. Failure to do so, however, means you're paying -- you're, as it were, discriminating against the people who do use them.

So it's not redistribution, you've got a distribution problem.

DR. WAKEFIELD: But the point is there is a class of hospital then that's probably going to be adversely impacted, although we're trying to minimize that adverse impact; right? Is that correct? either way.

MS. BURKE: Either way.

MR. HACKBARTH: So if we have agreement on this basic point, then the question I would ask is are we obliged to be specific in exactly how the Secretary ought to set these national rates? Or is, in fact, that maybe beyond our competence?

DR. NELSON: It is.

MR. DEBUSK: It is.

DR. REISCHAUER: But we want to say there's two types of rates he's setting. One, he looks at market conditions because it's not predominantly a Medicare application. And then there's the other, which are heavily Medicare focused. And we punt. We're price-setting but we don't want to admit it.

DR. WORZALA: If we're taking Medicare share -- when we started this, we were thinking okay, we're going to leave eligibility criteria alone because they seemed to be moving in the right direction and focus on the actual payment methodology. It sounds like we also want to be addressing eligibility criteria.

In which case, we would want to draft a recommendation that said something like the Secretary should

add consideration of Medicare share to the eligibility criteria? Or the Secretary should add a dollar cost threshold to the eligibility criteria? Something along those lines.

If that's what you want to do, we're happy to play around with those words and bring them back to you. I'm not sure we can do that right now.

DR. REISCHAUER: No, I think eligibility for consideration we go back to Joe's original point, which is is it a dollar value above some minimal threshold, $100 or $200, and a relatively high percent of the APC? Non-swallowable is what we're really looking for.

And then once you've jumped those two thresholds, then you can be considered for these additional payments and you divide everything into two categories. One for which the Secretary can look at market information and come up with a meaningful price. And the other which he'll have to set through -- like he does -- right.

DR. WORZALA: I have a problem with that concept because the pass-throughs are put in place for new technologies for which there is no market information. The concern in the past has been that it's taken Medicare too

long to wait for information to set payment rates, so that new technologies weren't being paid for adequately in the interim. So I'm not sure how directing the Secretary to gather market information helps us solve the underlying problem, which is that Medicare was perceived as a poor payer for new technologies in the first years that they're introduced.

And remember that this is a two to three year additional payment. And one of the reasons we wanted to move to national payment rates was so that the charge data that CMS uses to estimate costs is uncontaminated by the incentive to raise charges to maximize additional payments through the pass-through.

DR. NEWHOUSE: So maybe the eligibility is only on share because that's -- or estimated forecasted share. Because if I set a very high price -- take erythropoietin. If I said $500 a dose instead of $11 a dose initially, that's what ultimately would get folded into the rate. So it's with me forever. It's not just two or three years.

DR. WORZALA: Yes and no. It depends on how the hospitals charge, because it is the charge data that's used for folding it into the rates, not the pass-through.

DR. NEWHOUSE: They're probably not going to charge less than their cost.

DR. WORZALA: True. As we've all said, there is no right answer.

DR. ROWE: We had a longer discussion on this than we had on all the payment --

DR. ROSS: So I guess the question is whether we try to craft a recommendation overnight that meets this or whether we write a chapter that does not have recommendations but lays out the issues and some principles. I was just saying to Glenn that a recommendation as a statement of principle isn't entirely helpful because there's no action to it. We can work through these discussions in the text and that is presumably helpful.

DR. ROWE: Is this required?

DR. ROSS: Under our broad mandate to advise Congress on Medicare payment policy. There's not a specific statutory mandate. I mean, this is obviously one of the live payment issues, as evidence by the discussion.

MS. BURKE: But I wouldn't want our absence to have a specific recommendation to suggest that we don't agree, in fact, that there ought to be a supplemental

payment for a period of time that allows the entry of new technology. The debate here is not about that, it's about how we get there. So I wouldn't want there to be any confusion about our desire to go there.

MR. HACKBARTH: I think the principles, if you will, that we agree on are substantive. These aren't airy, abstract ideas. In fact, they reflect some dissatisfaction with the current state of affairs. It's an agreement that there ought to be some supplemental payment but the current mechanism isn't working very well. I think that's important to say, and important to say in boldface, as opposed to buried in the text.

I am not very optimistic that we are going to be able to get too much further in terms of defining with great specificity what the thresholds ought to be and what the price-setting mechanism ought to be. So my inclination would be to ask Chantal and Dan to come back with a recommendation that captures those broad principles and vote on that tomorrow and leave it at that.

Do people feel comfortable with that? Everybody except for Chantal, and she doesn't count.

DR. WORZALA: I just want to clarify. Is there

agreement that we want to move to national payment rates?

MR. HACKBARTH: Yes. The only question is how.

DR. ZABINSKI: You said broad principles, but I'm still not 100 percent sure what the broad principles are. To make sure, I'd like a list of what these things are.

MR. HACKBARTH: Let me try it again. One is that there ought to be temporary supplemental payments for expensive new technology so as not to impede the adoption, non-swallowable technology.

DR. WORZALA: That is recommendation language.

MR. HACKBARTH: So that's number one. Number two is that we ought to limit that class, as far as reasonable, and in the text we can say that the current system, we think, has made the door way too big and there's too much cramming through.

Number three is that when there are items that qualify for the supplemental payment, we need to pay for them with national rates in a manner that is not inflationary and inherently increasing the cost for the program.

I think those were the major items. Am I missing

anything?

MS. BURKE: [Inaudible].

MR. HACKBARTH: Given what's happening on the inpatient side that there ought to be some parallelism in what we're doing for the inpatient and outpatient pieces of the puzzle.

MR. SMITH: It seems to me we've also agreed that the limiting tool ought to be relative cost.

MR. HACKBARTH: High cost relative to the APC.

DR. NEWHOUSE: That's the swallowable.

MR. HACKBARTH: That's the correct way of putting it.

DR. WORZALA: Given what we know about the introduction of more stringent clinical criteria, and the cost criteria as they exist, and the predictions by CMS and industry that there will be small numbers going through the pipeline in the future, do we want to further limit beyond what exists? Which is, of course, different than what resulted in the problem of last year and moving forward without a different existing set of criteria.

MR. HACKBARTH: You're saying, Joe, that we ought to say this is in the right direction but not far enough?

DR. NEWHOUSE: If the new erythropoietin turns up, there's some replacement for it. There's a new renal dialysis drug, let's say. The problem is there.

MR. HACKBARTH: Let me just make sure I understand what you're saying. Chantal was saying CMS has moved in this direction to tighten things up. Are we saying they haven't done far enough? Or are we not passing judgment on that point?

DR. NELSON: No, we're not. Just anticipating the future.

DR. NEWHOUSE: If I understand where they've gone, we're saying they may have gone a bit too far in that they're -- I'm sorry. The issue is for the class that's left, how the reimbursement is going to be set?

MR. HACKBARTH: No. They've adopted clinical and cost criteria to try to limit the number qualifying for special treatment.

DR. NEWHOUSE: Right, so once we've limited, then the issue is how do we pay for what's still left?

MR. HACKBARTH: Agreed. But the question I hear Chantal asking is are we making any comment on what CMS has proposed, in terms of clinical and cost criteria? Or are we

just not addressing them at all? Is that right?

DR. WORZALA: This would be the issue of adding a cost threshold, for example.

MR. SMITH: They have a cost threshold.

DR. WORZALA: I'm sorry, I meant a dollar amount threshold, excuse me.

MR. SMITH: What they don't have in current procedure is a price setting mechanism. But they do have a set of entry criteria which are based on share that are designed at least to meet one of our criteria, which is to narrow the universe.

But where we're stumbling is not on whether or not we agree with what Chantal referred us to on page nine, but the next step. Which is having created the class how do you price it?

DR. NEWHOUSE: Yes.

MR. HACKBARTH: So we're prepared to say that the threshold criteria are moving in the right direction. It begs the question of how to set the price. We don't have a definitive answer to that, but it ought to be a national rate that's non-inflationary in the mechanism.

DR. NEWHOUSE: And we're taking Sheila's point

that you should think about this for the inpatient side as well.

MR. DEBUSK: Let's take a break.

MR. HACKBARTH: Do you have that in terms of what we're trying to capture? I'm not sure that every word or phrase of that needs to be in the boldface recommendation. Some of it can be relegated to the text. I'd be happy to talk to you about which is which, but that's the essence of the message.

DR. REISCHAUER: Not to go back to Capistrano and the swallows here, but I'm not sure that what you've described here is a very stringent test at all. It has to be 25 percent of the APC and exceed the thing it replaced by 25 percent. Well, if the thing it replaced was 25 percent of the APC, you're talking about the marginal cost is 7 percent of whatever the APC is, which strikes me as a pretty easy swallow.

DR. WORZALA: The next criterion on page nine is 10 percent of the total payment rate. So you're right about the 7 percent. 7 percent wouldn't cut it. It has to go up to 10 percent. We can say 10 percent isn't enough, but I guess it would depend if your APC is $10,000 or $100.

MR. DEBUSK: Some of this new technology, some of these devices, I mean what's that new stent? That new stent is what, $1,900 a piece and it usually takes two per procedure. So you've got to be careful when you're putting a cap on top of an existing rate.

DR. ROWE: No, they're talking about a minimum, not a cap. They're talking about it's got to cost at least X in order to qualify, not putting a cap on it.

MR. HACKBARTH: I think it's beyond our purview to try to pass judgment on specific numeric thresholds. I wouldn't want to do that. We need to make directional statements, as opposed to numeric statements here. We could talk about this for the next year and not get consensus on specific numbers.

Okay, we're going to take a brief break, 15 minutes. We'll reconvene at 3:30.

[Recess.]

MR. HACKBARTH: The next item on our agenda is assessing payment adequacy and updating Medicare payments for outpatient dialysis, skilled nursing facility care, and home health. Nancy?

MS. RAY: Thank you. I am here to discuss

updating payments for dialysis services for 2003. The general purpose of the update is to implement a compensating adjustment if payments are too high or too low, and to provide for payments to change at the rate of efficient providers' costs.

The reason that we care so much about the update is that we want to ensure that beneficiaries continue to gain access to high quality care.

So parallel to the Commission's update framework, my presentation is divided into two parts. In the first part we look at evidence about payment adequacy. In the second part, we look at how much efficient providers' costs are expected to change in the coming year. As you recall, the two parts of our update framework can possibly each result in a percentage change, which are then summed to determine the final update recommendation.

I conclude my presentation with a draft recommendation about updating payments in the coming year.

This graph shows the most current data that we have about Medicare's payments and providers' costs. The new data point on this graph that you haven't seen before is the payment-to-cost ratio for composite rate services and

separately billable drugs in the year 2000. We calculated that to be 1.05. As you can see from the graph, payment-to-cost ratio for just composite rate services dropped from 0.98 in 1999 to 0.96 in 2000. The broader payment-to-cost ratio also dropped by two percentage points, we think primarily because the composite rate in the year 2000 was updated by less than market basket, 1.2 percent, and there was a price increase for erythropoietin by 3.9 percent.

A couple of other points I'd like to talk about, about this graph. First of all, these data are for freestanding dialysis facilities only. Hospital-based facilities represent about one-fifth of all facilities. There is no evidence that we are aware of any differences in patient acuity between freestanding and hospital-based facilities.

The other important point is that the four data points you see on that graph, they represent unaudited data. HCFA has not regularly, on an annual basis, audited cost report data. BBA required CMS to audit cost report data and they did so with the 1996 cost reports.

So this raises the issue that has been raised before about Medicare allowable costs. The cost reports are

supposed to include only Medicare allowable costs. The four data points you see are unaudited, and to a certain extent they probably do include non-allowable costs. The effect of auditing the data and pulling out those non-allowable costs would be to raise the line. If you wanted to include non-allowable costs, then you would be lowering the four data points.

I guess I just raise that as an issue for you to consider. I don't propose, at this point, to make any adjustment to the data points that you see there. The treatment of non-allowable costs, how we treat non-allowable costs when we examine payment adequacy is a cross-cutting issue. I think staff are planning to do additional work on this topic and at this point we would like to defer any final action on how we treat allowable and non-allowable costs for the future.

Our findings that payment for dialysis services did not cover providers' costs could imply that payments are too low or that costs are too high. Many experts believe that Medicare overpaid for dialysis services for much of the '80s and even into the '90s. It appears, at this point, that providers' costs for composite rate services have

caught up with Medicare's payment rate. Congress only updated the payment rate once during the 1990s, by $1 in 1991.

We conclude, in your briefing paper, that costs for composite rate services do not appear to be inappropriate.

Our finding that payments for injectable medications not included in the payment bundle significantly exceeded providers' costs between 1997 through 2000 could imply that payments are too high or costs are too low. In this case, it is highly probable that Medicare pays too much for certain of these injectable medications. GAO and OIG have concurred with our finding about this.

So what's going to happen after 2000? We do not really know how dialysis costs for composite rate services have changed in 2001 or will change in 2002. Consequently, we assume that providers' costs will increase at about the same rate as the market basket.

Just as an FYI, Congress did not update the composite rate payment in 2002. Last year your recommendation was not to update it for 2002. And current law does not include any update to the composite rate for

2003.

The other factor that we do know that's going to happen in 2001 is that the price of EPO went up again. The manufacturer raised it again by another 3.9 percent.

We estimate that the payment-to-cost ratio will drop roughly by two percentage points in 2002 if we assume that composite rate costs continue to increase at the market basket. And the split between the composite rate payments and separately billable drugs remain at that same split, which is roughly 61 percent to 39 percent. And three, that the payment margins for other separately billable drugs stay at the 2000 margins. Again, there's some tenuous assumptions there, but I think it will give you a feel for what might happen in 2002 if the composite rate is not increased.

MR. HACKBARTH: So, Nancy, you're saying that the best guess, with qualification, with some uncertainty, is that the payment-to-cost ratio went down by 2 percent each for the two lines. So for the composite rate only it would be 2 percent lower. And for the composite rate plus separately billable drugs, that would also be 2 percent lower?

MS. RAY: No, the last estimate for 2002 is the broad-based ratio, the composite rate and separately billable.

MR. HACKBARTH: So if that's at 1.05, you're saying our best guess is it would be 1.03 for 2002?

MS. RAY: Yes.

DR. NEWHOUSE: Nancy, do you know when the original formulation of erythropoietin is going off patent?

MS. RAY: I don't know that, and I think what's very tricky about that is because -- and again I'm not an expert on this -- but because it's a bioengineered drug, there may be patents on the manufacturing process, as well as on the drug itself. I can look into that.

Now there is a new drug that has just been approved. The same manufacturer who makes erythropoietin is making this new drug. It's a once a week EPO.

DR. NEWHOUSE: I know. That's why I asked about the original formulation. I thought it was about to go off patent.

DR. REISCHAUER: The letter we got said, for some years to come that it was still on patent.

MS. RAY: I can look into that and get back to you

on that.

MS. BURKE: Nancy, I'm just interested in this. Do I recall that initially the acuity of patients in the inpatient or the hospital-based facilities, as compared to freestanding, was in fact different? Has that changed? You noted that they appeared to be quite similar.

MS. RAY: There is no recent evidence of any difference in patient acuity. It's my understanding, but again I wasn't around back then when the composite rate was originally set, was that the difference in the base payment rate was a difference in providers' costs.

DR. ROWE: There may be a distinction here, Sheila, that maybe isn't clear. First of all, I think that Nancy is speaking about dialysis facilities that are attached to hospitals.

MS. BURKE: I understand that.

DR. ROWE: As opposed to inpatients who are being dialyzed.

MS. BURKE: I understand.

DR. ROWE: The inpatient is being dialyzed, there would be an acuity. In addition, we're only talking about Medicare beneficiaries and thus, the acute cases would not

yet -- unless they're already over 65 and a Medicare beneficiary -- they would not yet be in the ESRD program.

MS. BURKE: Sure they would.

DR. ROWE: No, if you're a 45-year-old and you get acute renal failure and you're insured by Aetna, Aetna pays for your dialysis.

MS. BURKE: If you're just acute. But if you're acute disabled, your Medicare.

DR. ROWE: For the first 30 months, not three months.

MS. BURKE: Unless you triggered into disability and then if you're DI then you qualify for Medicare, you kick in.

DR. ROWE: I was surprised also when I heard this, but I was just thinking that maybe it's because my bias is that the inpatients are part of the hospital program.

MS. BURKE: I'm literally recollecting back to the late '70s, early '80s when I recall, for some reason, that the hospital-based non-inpatient patients had a higher acuity. But my recollection may be wrong.

MS. RAY: I really can't comment about the late '70s, early '80s.

[Laughter.]

MS. RAY: What I can say is that I haven't --

DR. ROWE: Don't say anything.

MS. RAY: There's just one point I want to make about this 2002 prediction, why I think it's tenuous. That is because it's based on the split between payments for composite rate services and separately billable drugs. We've seen, in the last four years that we have data, the significant growth in the use of separately billable drugs. To the extent that they continue to increase that, of course, will affect margins.

We look at other factors to assess payment adequacy, in addition to the margin data. We talked about this at the December meeting. We look at changes in the product, and again we discussed this in December. We have seen, in the '90s, more in-center hemodialysis versus peritoneal dialysis occurring, even though costs for peritoneal dialysis are less but the payment rate is the same.

We have seen, like I just said, about the significant increased use in separately billable drugs. For example, for drugs other than erythropoietin, allowed

charges went from $281 million in 1997 to about $605 million in the year 2000.

Now this has come with continued improvements in quality of care. There is concern, however, that because these are cost-based payments there is the potential for inappropriate use.

We talked about provider entry and exit and we discussed the increasing number of facilities opening. There was a question about is there sufficient capacity. I tried to look at that in terms of average stations per facility, average treatments per facility, and treatments per dialysis station.

It appears to me, the conclusion I drew from this information, is that these three figures have stayed relatively constant between 1993 through 2000, and that capacity has increased by building more facilities rather than expanding existing facilities. The best I can say is that, linked with the fact that we haven't seen any systematic problems in access to care, would lead me to believe at this point that capacity is sufficient.

And the other issue that is new to this slide is that we did look at differences in facilities that stayed

open between 1993 to 2000 and facilities that closed. Where you saw differences, facilities that closed were more likely to be hospital-based and to be small, to provide fewer number of dialysis treatments and have fewer number of stations. There were very small differences between the facilities that stayed open and closed in treatments paid for Medicare or by location.

MR. HACKBARTH: Nancy, on that last point, are you saying that there is no evidence that facilities that treat more Medicare patients were more likely to close?

MS. RAY: Right. I just did not see that. The facilities that were more likely to close, and where you see the big, big difference, is if they were hospital-based they were more likely to close and if they were smaller.

Based on the information about payment adequacy therefore, staff conclude that total outpatient dialysis payments are not inadequate. At the end of my presentation, and once you start discussing this, I would ask that you explicitly discuss that conclusion. The update recommendation is, of course, predicated upon that conclusion.

Like Tim spoke about earlier today, CMS has not

yet developed a market basket index for dialysis. They're currently doing so. They're supposed to have that report to the Congress July of 2002.

We have our own market basket. The market basket uses information from price indices for PPS hospitals, SNFs, and home health. Using our market basket, we estimate that costs will rise 2.4 percent between 2002 and 2003.

So that leads us to our draft recommendation. This draft recommendation is that for calendar year 2002 the Congress should update the composite rate for outpatient dialysis services by 2.4 percent to account for changes in input prices in the coming year. This is based on staff's conclusion that payments are not inadequate and that we are not taking any adjustment because of payment adequacy.

DR. ROWE: This is a change in the 2.6 percent that you sent out.

MS. RAY: It is, yes. And that's because I used fourth quarter data, which is more recent data than the last time. Thanks for noticing.

MR. HACKBARTH: Comments or questions for Nancy?

DR. NELSON: Nancy, I certainly support the recommendation, although I like the 2.6 better. But I want

to comment on the injectable medications and some of the assumptions that seem to be made based on volume. Indeed, the increase in volume of injectables may be perfectly appropriate. Unless there's some evidence that they're exceeding clinical guidelines, I'd hesitate to draw conclusions.

Furthermore, if I put myself in the position of a patient that is confronted with either receiving medication in an IV that's already in place or getting a shot every time, or either having vitamin D intravenously or having to come up with $10 a month to buy it as an uncovered benefit, it's easy for me to justify the increased volume of injectables based on the patient comfort and perhaps even the quality of care, rather than just being something related to compensation.

MS. RAY: One piece of information from the audience. The audience person says the EPO patent extends until 2014.

DR. ROWE: Isn't that a long time? How long is it usually?

MR. DEBUSK: 17, now it's up to 20.

MS. RAY: It was approved in 1989, that I do know.

I'm pretty sure about that.

MR. HACKBARTH: Other comments or questions?

Nancy asks that, although it wouldn't be a recommendation, that we specifically address whether the existing payments are adequate. I take it our best estimate of 2002 is about 1.03 for the payment-to-cost ratio for composite services plus separately billable. It sounds to me that that falls within our range of adequacy. Any disagreement with that?

DR. REISCHAUER: Remind me, what is our range of adequacy? I'm sorry.

MR. HACKBARTH: We have not adopted a specific numeric range.

DR. REISCHAUER: Then I think this does fall within the range.

MR. HACKBARTH: Thank you for that contribution, Dr. Reischauer.

[Laughter.]

MR. HACKBARTH: Okay, are we ready to vote? Are we prepared to vote?

All those opposed to the draft recommendation?

All in favor?

Abstain?

Great. Thank you, Nancy.

Next is skilled nursing facilities.

DR. KAPLAN: Good afternoon. As Glenn said, we're going to talk about payment adequacy and updating payments for skilled nursing facilities. At the end of my presentation you'll need to recommend how SNF payments should be updated for fiscal year 2003.

We have three key questions to consider today, whether the base payment is adequate, whether the distribution of payments is appropriate, and what the update should be. The answers to these questions are complicated by not knowing whether CMS will refine the RUG-III, the SNF classification system that hasn't been effective in distinguishing among patients and resources needed for care. Whether RUG-III is refined or not will affect payments.

We looked at a number of indicators to assess payment adequacy, one of which was Medicare margins. To model estimated SNF costs and payments for fiscal year 2002, we used the same method as used for the hospitals. We used fiscal year 1999 as the cost base. We increased costs by market basket for 2000 through 2002. And increased payments

by update factors. Because we're making a recommendation for payment in fiscal year 2003, we modeled payments and costs with payment policy that will be in effect in that year.

As you know, Congress enacted a series of temporary rate increases for the SNF PPS. We've given these add-ons names so everyone can be clear about them and what we did with them in the modeling. We found it very confusing and we were constantly having to explain them, so we've given them names. We've named them add-ons X, Y and Z.

None of the add-ons was in effect in 1999. Add-on X was a 4 percent increase across all the rates. Add-on Y was a 16.66 percent increase in the nursing component base rate. Both add-on X and Y expire in fiscal year 2003. We did not include either of these add-ons in our modeling as a result.

Congress put add-on Z in place to give CMS time to refine the RUG-III. This is a 6.7 percent increase in rates for rehabilitation patients and a 20 percent increase for medically complex patients.

DR. ROWE: Sally, when you say they expire in

fiscal year 2003, does that mean they expire at the end of 2002 or at the end of 2003?

DR. KAPLAN: At the end of 2002. As of September 30, 2002. That's under current law.

CMS has signaled their intention to refine the RUG-III but we don't know whether they will accomplish this task. Therefore, we've modeled 2002 payments with and without add-on Z.

Our estimates of costs for 2002 are likely overstated because we use the first year of the PPS as the cost base, fiscal year 1999, and we increase costs by full market basket after 1999. We made no adjustment for behavior change. However, experience with other PPS' suggest that SNFs continued to cut costs as they had more experience with a PPS.

We know that hospital-based SNF costs are overstated because hospitals allocate some costs to their SNFs, they have a higher case-mix, and appear to have a different product than freestanding SNFs.

To come up with our best estimate of hospital-based SNF costs we started with freestanding SNF costs because they are able to deliver SNF care under the PPS. We

also considered the difference in case-mix and product for the two types of facilities. Hospital-based SNFs had an 11 point higher case-mix compared to freestanding SNFs in 1999 according to our APR DRG analysis that we reported on last year and since.

Hospital-based SNFs also appeared to have a different product than freestanding SNFs. They have a different staff mix, more licensed staff, and an average length of stay about one-half that of freestanding SNFs. After increasing costs for case-mix, we added half the remaining difference in costs, and that may be on the high side. Our best estimate is that reasonable costs for hospital-based SNFs equal freestanding SNFs costs plus 30 percent.

The table on the screen shows the Medicare margins estimated for 2002. First, I'd like you to focus on the line for the margin for all SNFs, which is in blue. Just as a reminder, in 1999 no add-ons were in effect. As you can see, the Medicare margin for all SNFs is about 5 percent with add-on Z. Without add-on Z, the Medicare margin drops to almost negative 5 percent. Add-on Z represents about a 9 percent increase in payments.

The Medicare margin for all SNFs for 2002 suggests that the base payment rate is adequate with add-on Z. Without add-on Z, the base appears to be inadequate. The other factors we examined also suggest that the base rate is adequate. Freestanding SNFs are staying in the program, beneficiaries have had stable access to care in 2000 and 2001, and most SNFs appear to have access to capital. A study by the National Investment Center for Seniors Housing and Care Industries indicates that independent SNFs and small to medium-sized regional chains, which together represent 47 percent of the market, on average were able to increase their net operating income and debt service coverage from 1998 to 1999.

DR. BRAUN: Are the X and Y add-ons taken out of the modeling for 2002?

DR. KAPLAN: X and Y were never included in the modeling. The modeling is 1999 and 2002 with 2003 policy. So they're not in the modeling at all, X and Y.

MR. HACKBARTH: Sally, I'm sorry, could you repeat what you said about debt coverage?

DR. KAPLAN: Yes, I can. The National Investment Center for Seniors Housing and Care Industries did a

national study. They indicate that independent SNFs and small to mid-size regional chains, which together represent about half of the market, were able to increase their net operating income and debt service coverage from 1998 to 1999. They increased it from about 11 to 12 percent to above 14 percent on the net operating income.

MR. HACKBARTH: That's for their whole book of business, Medicare and Medicaid?

DR. KAPLAN: Yes.

We have the same table on the screen now, but we've highlighted the margins for the two types of SNFs this time. The margins are very different, as you can see. With add-on Z, freestanding SNFs have an estimated 9.4 percent Medicare margin in 2002. Without add-on Z, these SNFs still have a positive margin but it drops to 0.4 percent.

Hospital-based SNFs, even after accounting for differences in case-mix and product, have very low margins, minus 21 percent with add-on Z, minus 33 percent without the add-on.

Assuming that add-on Z remains in place, the margins and other factors we examined in assessing payment adequacy suggest that the payments are more than adequate

for freestanding SNFs. Payments appear less than adequate for hospital-based facilities. The continuing departure of hospital-based SNFs from the Medicare program and negative margins beyond what we would expect suggest payments are not adequate for these facilities.

However, even with these negative margins, hospitals still have an overall Medicare margin of 3.8 percent, as you'll remember from earlier this afternoon. SNFs represent 2 percent of hospital payments.

MR. HACKBARTH: Sally, remind me, is the hospital-based row here after some adjustment for cost accounting.

DR. KAPLAN: Yes. We basically, instead of taking the cost accounting out, what we did is we started with the freestanding's costs and then added for case-mix and product difference. Basically, these rates are freestanding costs plus 30 percent.

MR. HACKBARTH: So this is our best estimate of the real economic situation?

DR. KAPLAN: Yes, that's our best estimate of reasonable costs, was the way that we described it.

To account for cost changes in the coming year we begin with market basket. We expect SNFs to continue

finding additional ways to cut costs under the PPS. The phase-in, which ends in fiscal year 2002, was designed to give facilities time to adjust gradually to the PPS. We think they will continue to adjust in the coming year, even after the phase-in is complete.

Now we will review our conclusions. If add-on Z expires, payments won't be adequate. Therefore, it appears that the add-on Z should be incorporated into base.

Freestanding SNFs' Medicare margin of 9 percent and their continuing in the program suggests the payments are more than adequate. Therefore, they do not appear to need an update.

Even after the adjustments we've discussed, hospital-based SNF payments appear to be less than adequate. This suggests payments should be updated by market basket and that money should be added to the base rate pending development of an effective classification system.

The draft recommendations are on the screen and collectively, the last three provisions -- the things shown by bullets -- are essentially equivalent to market basket minus 1 percent.

DR. ROSS: If I could just clarify, that very last

bullet is subordinated to for hospital-based facilities.

DR. KAPLAN: Basically we're going to update the payment rate amount by market basket for hospital-based facilities, not freestanding.

DR. ROWE: Do you have total margins in addition to Medicare margins? This is one of the kinds of facilities where we really got into the question of Medicaid and Medicare and the balance, et cetera.

DR. KAPLAN: I don't have them on a slide. I have them for the freestanding SNFs.

DR. ROWE: What are they?

DR. KAPLAN: Negative 2 percent.

DR. ROWE: So the total margin is negative 2 percent, including this Medicare margin?

DR. KAPLAN: Yes, everything.

DR. ROWE: You don't know what it is for the hospital-based?

DR. KAPLAN: Because you would get the most of Medicare margin that you get in the hospital base, which is 3.8 percent.

DR. ROWE: I was just looking for the SNF itself rather than for the whole hospital.

DR. KAPLAN: Their margin would be their Medicare business for the SNF. I mean, that would be their total margin. Most of the hospital-based SNFs don't take any Medicaid.

DR. ROWE: Or private.

DR. KAPLAN: No. They might have some commercial, but...

MR. SMITH: Does the first paragraph of the recommendation refers not to add-ons X, Y and Z, but only add-on Z; is that correct?

DR. KAPLAN: That is correct.

DR. NEWHOUSE: How would I know that?

MS. RAPHAEL: You know that because that one is tied to when the refinement of the classification system occurs. When that's declared refined is when add-on Z is due to expire; right?

DR. KAPLAN: Right. We didn't think the Congress would know what add-on Z was so basically -- I'm sorry, it's true. So this is the only add-on that was specifically put in place to allow CMS time to refine the RUGs and expires when CMS states that the RUGs are refined.

MS. BURKE: I'm sorry, I want to make sure I

understand this because of the variance between hospital-based and freestanding. It is your intention to retain, for all facilities, the current temporary adjustment. It is then your intention to provide an update, market basket update only for the hospital-based? Correct?

DR. KAPLAN: That is correct.

MS. BURKE: So let me understand bullet two. In bullet one, you're saying you freeze the base. That's freezing the base with the current temporary adjustment. Point two is for the hospital you freeze the base, which includes the temporary, plus you add 10, plus you add market basket?

DR. KAPLAN: That's correct.

MS. BURKE: Then point three, update the base by market is only for hospital-based?

DR. KAPLAN: Right, and you included that when you were rephrasing bullet two. They're getting a market basket update plus 10 percent.

MS. BURKE: Right. Can I simply suggest that you might want to think about you rephrase this so it's explicit? It may be I'm just show in getting it.

DR. KAPLAN: Also part of the confusion is because

the last bullet should say for hospital-based facilities.

MS. BURKE: Right, but make it explicit that it is our understanding -- and I mean you do sort of in that opening paragraph, but say the presumption is that the temporary adjustments remain in place which equal X percent, and that we assume that's the base. And it's on that base we then build.

MR. SMITH: But in that regard it does seem to me we need to be clear, at least so we understand, maybe Congress will or won't, that at the moment if somebody looks at the payment structure there are three temporary payments. We're only talking about rolling one of them into the base and we need to say that in a way that someone who now thinks there are three doesn't think we're talking about three.

MR. HACKBARTH: I just need a clarification on what Sheila just went through. So the second bullet, increase the base by 10 percent until an effective classification system is developed. What if CMS tomorrow says we've fixed the problem.

DR. KAPLAN: Basically last year, as most of you will remember, we recommended that CMS develop a new classification system for skilled nursing facility patients

because of the deficiencies of the RUG-III. And we stated, at that time, that we didn't think it could be refined to be an acceptable case-mix system. We outlined four problems with the case-mix system. And basically, even if they really got it a whole lot better, some of those problems would still remain that would not be solved.

MR. HACKBARTH: With regard to the one temporary payment, didn't Congress vest CMS with the decisionmaking authority about when the system was fixed?

DR. KAPLAN: Yes. It said until the RUG-III is refined. So it did not refer to another classification system.

MR. HACKBARTH: So the first paragraph is driven by CMS' decision about when RUG-III is refined. The second bullet is driven by our judgment about when they've come up with an adequate new system.

DR. KAPLAN: That's correct.

MR. HACKBARTH: That's a little tricky for people to follow. That will need some --

DR. ROSS: You're also on to a point that it's hard to craft a recommendation because we're seeing this currently where if you just leave it to somebody else to say

it's new and improved, and they declare it to be new and improved, we couldn't come up with foolproof language. But I think we can convey the point in the text.

DR. REISCHAUER: Sally, explain to me really what's happening here. Z is an add-on that refers to two categories of folks. When we're saying that we need to build Z into the base, are we talking about the distribution or are we talking about taking that 9 percent and just raising the whole distribution?

DR. KAPLAN: We're talking about raising the base, the whole thing, for all SNFs. And it basically comes out to 9 percent. 75 percent of the patients are rehab patients, 22 percent are in this medically complex, and the other 3 percent are people who never got an increase in rates under this add-on.

DR. REISCHAUER: So then we're basically saying if we do that, I gather, that 9.4 percent margin falls into our range of --

DR. KAPLAN: No. First of all, that leaves everything the way it is. Then, if we do not give freestanding SNFs an update, then that will bring their margin down.

DR. REISCHAUER: Three percentage points or so.

DR. KAPLAN: The market basket forecast at this moment is 2.8 percent but that obviously is subject to change. I used the actual market basket forecast and I came out with about 7 percent, is what their margin would be.

DR. NEWHOUSE: This is a minor change. I think we mean we want to increase the base rate by 10 percent, rather than 10 percentage points, in the second bullet? You can't increase a rate by 10 percentage points.

DR. KAPLAN: Thank you.

DR. WAKEFIELD: Just out of curiosity I want to ask you one question and see if I understood something correctly that you said, Sally. Did you say that most hospital-based SNFs do not take Medicaid patients?

DR. KAPLAN: Yes.

DR. WAKEFIELD: That's because?

DR. KAPLAN: When I say Medicaid patients, I'm referring to custodial patients. I'm not talking about people who are acutely ill that are paid for under Medicaid. I'm really talking about the custodial patients.

DR. WAKEFIELD: Then the second part of that, in the text you indicated that about 20 percent of hospital-

based facilities have left the Medicare program. We don't know what of that 20 percent that have left the Medicare program are rural versus urban, do we?

DR. KAPLAN: No, we have not done that work.

DR. WAKEFIELD: In part I'm asking that question because, obviously, a high proportion of rural hospitals provide SNF care.

Just a comment on the text. If this text stays, there's a good paragraph talking about anecdotal evidence that speaks to cost-cutting on the part of SNFs to help hold their costs down using therapy assistants instead of therapists, using licensed nurses instead of respiratory therapists, et cetera, et cetera. I'd appreciate just a little bit of a caveat in there that says something about we know that they've been effective, it seems, at cutting their costs. We can't say anything about what impact that may have had on quality. So it sounds good on the face of it but I haven't a clue from that what impact, if any, that's had on quality of care.

MR. DEBUSK: If you would, help me understand. I'm a little slow here, Sally. To peel this onion a different way, as I understand it right now, X, Y and Z adds

up to about $60 a day. Is that right or wrong?

DR. KAPLAN: At this point I don't know. I've seen that. That's what the industry, but I don't know that.

MR. DEBUSK: Now when X and Y goes away, which it will, of that $60, would I be safe in saying that that would probably leave about $30?

DR. KAPLAN: I don't know.

MR. DEBUSK: I'm trying to figure out, out of whatever they're getting now, what are they going to end up with. It's very complicated, and you wonder what's behind the numbers in going forward. But say it is $60 and $30 comes out of it there. And then we've got Z, and we go into next year, and the stand-alone no longer gets the market basket of 2.8 percent, and what does that translate into? Effectively, what does that reduce that to?

DR. KAPLAN: Instead of dollars, I think the relationship of payments-to-cost is really what we've looked at, rather than straight dollars. And that is that we have not done the work to basically say what it would be, what their margins were with add-ons X and Y in place. I mean, we clearly know they'd be 4 percent higher because there was a 4 percent add-on in place. But the 16.66 percent, which

is built into the nursing component base rate, is a lot more complex to figure out.

DR. ROSS: Sally, could I interrupt? Pete, just to follow upon Sally's point, that we haven't done this on a per diem basis but on a margin basis, that table that was up that showed the report of margins in 1999 compared with modeled margins in 2002, the 9 percent was prior to any of these add-ons. The model 2002 is 9.4 or 0.4, depending on what happens to this third add-on.

But the other two to which you refer sort of came and went in the interval. But what we do know is that the margin had to be higher than 9 percent. The reduction in the cost per day, again I don't know exactly what that will be, but payments were certainly in excess of costs before those came along and would have continued to be after them.

MR. DEBUSK: I'm just looking at it trying to work out, in a simple manner, how many dollars are we taking away in the system if all this happens like we propose here? My concern is you know, we really had to bail this industry out at one time, and that's how we got here. And are we going right back there again?

DR. ROSS: There's where you see the draft

recommendation, though, is that given the current law possibility that that third add-on be taken away by a declaration of a refinement. And that would leave an essentially zero margin. Where we've argued that no, that money should be locked in.

MR. DEBUSK: Are we talking about 90 percent of that?

MR. HACKBARTH: The whole thing would be put into the base rate. So that's what that first paragraph is about.

MR. DEBUSK: Why shouldn't they get the market basket going forward, as well?

DR. ROSS: That amount of money -- that's a Commission judgment, but that amount of money would put them at a 9 percent margin. I think some might argue, at least on the Medicare line of business, that's beyond the adequate range.

DR. REISCHAUER: But I think what Pete is saying is they were at 9 percent margin in 1999, they then were in deep trouble in 2000 and 2001, and we put more money in. Then we're going to, in a sense, take it back out. Are they going to be in big trouble? But you're saying the big

trouble is due to other things.

MR. HACKBARTH: Let's put the issue squarely on the table. I think Jack alluded to it way back at the beginning when we were talking about the issue of what role do total margins play in our decision about Medicare rates. I think it was Bob who suggested that the relevance is if we're going to lose access to Medicare beneficiaries, total margins become relevant to the conversation.

Our best estimate of the total margins is a negative 2 percent. So I think the implication of Pete's point is is that too low? Should we increase the Medicare payments to freestanding SNFs in the name of maintaining access for Medicare beneficiaries?

DR. ROWE: To follow up on that. If we are able to adopt, at least subconsciously, a broader view of financial performance than just margins -- and we've talked about balance sheet stability, financial stability, credit worthiness, et cetera -- it would be interesting to know what has happened and is it happening through this most recent cycle with respect to the credit worthiness of these institutions and their access to capital?

DR. KAPLAN: Their access to capital from '98 to

'99 went up for the freestanding, independent, and small to medium regional chains. On the chains, on the large national chains, their net operating income dropped from 17 to 18 percent to 11 to 12 percent from '98 to '99. '99 is your base year here.

So those other two add-ons are on top of that. So it seems to me that --

DR. ROWE: How do you reconcile that with the minus 2 percent number that you gave us?

DR. KAPLAN: I don't necessarily do reconcile it with it. I'm just telling you that that's the study that the National Investment Center did. They went to the large lenders, the large established lenders that lend to this industry, and looked at their portfolios. And that's what they came out with.

And they compared that to an earlier study that had been done on the large chains.

DR. ROWE: So you're taking these capital issues into account when you give us your impression that the payment rate is not inadequate?

DR. KAPLAN: Yes. Let me just say, I think that it's your decision to decide whether Medicare should cover

Medicaid's costs. And my concern would be that that doesn't necessarily give these people any more money, because the more Medicare puts into the pot, it's very possible for the states to back it right out.

MR. HACKBARTH: We've had some people patiently waiting here.

MS. BURKE: Sally, I'm sorry to put this to you again, but I want to walk back for just a second and look at how what I think we're saying is structured and make sure I understand it. It is my understanding that the first paragraph is meant to make permanent as a part of the base temporary adjustment Z; is that correct?

DR. KAPLAN: That is correct. Permanent until it's -- you know, we will be reassessing it every year.

MR. HACKBARTH: But it would be redistributed.

MS. BURKE: I understand. There were three adjustments, X, Y and Z. X and Y are going away. We make no argument that X and Y ought to stay in play.

It is our belief that Z should become a part of the permanent base; correct? Do you, in any scenario, envision Z going away when they rebuild this system?

DR. KAPLAN: I don't think we can answer that because I think that -- all of this is based on 1999.

MS. BURKE: I understand. But for the moment, until we know otherwise --

DR. KAPLAN: Until we know otherwise, it would stay in.

MS. BURKE: We believe Z becomes part of the permanent base upon which we adjust.

DR. KAPLAN: Yes, ma'am.

MS. BURKE: Don't make me feel older than I am. Your highness, your royalness, but not ma'am.

Then I think we ought to say that. It's not clear from reading this that it is our assumption that the other two go away, and what we essentially are incorporating into the base is one aspect of what was a three-part adjuster.

Then I understand what you want to do is you want to make no further adjustment to that base for the freestandings, that's it. That's where they are.

Then you essentially want to do an additional 10 percent increase to the base, permanent for hospital-based?

DR. KAPLAN: No.

MS. BURKE: So it's not a permanent increase?

DR. KAPLAN: No, it's until an effective classification system is developed.

MS. BURKE: Whenever that is.

DR. KAPLAN: Right.

MS. BURKE: But the market basket increase is a permanent increase until everything else is in play?

DR. KAPLAN: Right.

MS. BURKE: Now is it my understanding that the Commission previously stated that a refinement was, in fact, not likely to be adequate? You believe the whole system needed to be replaced?

DR. KAPLAN: Yes, that's correct.

MS. BURKE: So why are we, throughout this thing, talking about all this is good until we refine it if we don't believe it can be refined?

DR. KAPLAN: This doesn't really refer to the refinement, except to say --

MS. BURKE: Yes, it does.

DR. KAPLAN: At the beginning we need a way to refer to this add-on Z. So if the temporary payments implemented to allow the Centers for Medicare and Medicaid Services time to refine the classification system expire,

really refers to add-on Z.

MS. BURKE: It seems to me that unless there's a reason not to do this that's historical, we ought to state outright that we continue to believe that the system can't be fixed. That it needs a new system. We ought to just say that and state that outright.

Then it seems to me we ought to say that we believe until such time as it's fully replaced, that this adjustment -- and describe what it is so there's no confusion -- this piece of it ought to be made part of the base until we put in place a new system.

I don't think we ought to look like A, we think a refinement is going to work; or B, that we're not clear about which of those we ought to do, if that's what your intention is.

DR. KAPLAN: All right, I understand what you're saying. Now we don't have a clear statement about add-on X and Y, because of the same reason that Chantal mentioned that generally one doesn't recommend that you follow current law.

MS. BURKE: But in this case we're explicitly providing for the continuation of something?

DR. KAPLAN: Yes, for add-on Z, yes.

MS. BURKE: Which does require a change in the statute.

DR. KAPLAN: Yes, it does.

MS. BURKE: So it seems to me, does it?

DR. ROSS: This is all a little bit more complicated than that, in part because the so-called add-on Z -- this is a contingent. Current law is it stays in place. The issue is whether it might go away if CMS decides to declare it refined this year. But there's no change in the statute. It can go away or continue with no change in the statute. That was item number one.

Item number two is you're referring to the term permanent.

MS. BURKE: It's just calculated as part of the base.

DR. ROSS: And words like permanent make me nervous.

MS. BURKE: Nothing's permanent.

DR. ROSS: I think the gist of this is that you put this money in place until a new case-mix classification, and presumptively effective class-mix classification system

is --

MS. BURKE: But we don't renegotiate this next year in the absence of anything else?

DR. ROSS: Correct.

MS. BURKE: That's my point. Is we presume this stays in the base until such time --

DR. ROSS: But presumably if and when you go to a new PPS, at that point you reassess everything else entirely.

MS. BURKE: My concern is just that it is not our intention, absent a complete reform of the system or whatever we're waiting for, that we're going to renegotiate next year whether or not this adjuster stays in place. This is in place until -- okay. We may want to sort of be overt.

MR. SMITH: On Sheila's point, it seems to me -- I mean, part of the problem I think comes from the use of base because that sounds permanent and we don't really mean permanent. We mean until the inadequate classification system is replaced.

But it seems to me we ought to link that point with what is now the second bullet in the second point. We're talking about two payment adjustments, one for all

SNFs and one for hospital-based SNFs, that we believe ought to be incorporated in the base rate until the classification system is replaced. And it seems to me rather than dividing those two thoughts, we ought to get them back together again.

DR. KAPLAN: I think one thing that I'm afraid you're misunderstanding is that this 9 percent, which we're calling add-on Z, we're talking about putting in the base rate for everybody. And I don't like the word permanent either, because we do reassess every year whether the base rate is appropriate or adequate. And we might decide in the future that it's more than adequate.

But then the 10 percent addition to the base for the hospital-based, we're saying that is only until a new classification system, a new effective classification system, is in place.

MR. HACKBARTH: So the triggering events are different.

DR. KAPLAN: Yes.

MR. HACKBARTH: For the first paragraph, a refinement of RUG-III could suffice. CMS says we've tweaked it here and there, it's better than it was. Under current

law that means the Z payment goes away. Under this recommendation we would say take that money then and put it into the base.

DR. KAPLAN: Yes.

MR. HACKBARTH: The second payment, the one that's the second bullet, its elimination is triggered when a whole new classification system is developed. A refinement of RUG-III does not suffice. That is, I think, the confusing part here.

MR. SMITH: But aren't we even more confused, Glenn? Because we're arguing that a refinement of RUG-III shouldn't even trigger getting rid of add-on Z, because we don't think it's possible to do it.

MR. HACKBARTH: The current law, as I understand it, provides that Z will go away if RUG-III is improved, or is declared to be improved.

DR. KAPLAN: Are declared to be improved.

MR. HACKBARTH: So we're saying in the event that happens, and it may happen relatively soon for all I know --

MS. BURKE: Do we think --

DR. KAPLAN: The word on the street is it will be

done for 2003, it will be declared as refined.

MR. HACKBARTH: So that's the event that we don't control that we expect to happen relatively soon. In the event it does, we're saying there should be a 9 percent increase in the base. So that money stays in the system, albeit in a redistributed fashion.

We continue to say that we don't think that's enough, enough improvement of the classification. Therefore, there ought to be a 10 percent add-on to the hospital-based until there's a whole new system put in place. That's what we're saying here.

MR. SMITH: I apologize. I am really confused now I think.

DR. NEWHOUSE: Glenn, let me suggest that we get rewritten wording tomorrow.

MR. SMITH: But I think we need to stick with this for a minute and make sure we understand what we'd like to see rewritten.

Sally says that the word on the street is that the declaration will occur before 2003. As this first part of the recommendation is written, that would mean that the 9 percent never got incorporated in the base, it went away.

But that's not what it says.

DR. KAPLAN: No. The word on the street is that the RUGs will be refined for fiscal year 2003. That the refinement will be announced in the proposed rule that comes out this spring and then is put into final rule in the summer, but becomes effective on October 1.

MR. SMITH: But doesn't the first half of the recommendation tell you, as drafted, say in the event that things transpire the way you describe --

DR. KAPLAN: That it actually happens, yes.

MR. SMITH: That the 9 percent then is not incorporated in the base.

DR. KAPLAN: No, then we tell them to incorporate it into the base.

MR. SMITH: That's not what it says.

DR. REISCHAUER: Why don't we say something like, when CMS refines the RUG-III and add-on Z expires, the resources devoted to this should be added to the base.

MR. DEBUSK: Word in edge-ways. What time? If this is the word on the street, why should we take the market basket for 2003 away from the stand-alone facility?

DR. KAPLAN: Because we're recommending to the

Congress that they add add-on Z to the base rate.

MR. DEBUSK: But that's going to go away.

DR. KAPLAN: No, we're recommending to the Congress that they put that money into the base.

MR. DEBUSK: Why do we have to make the market basket go away for this area?

DR. ROSS: Can we break this into two pieces? The first piece of this is an attempt to deal with payment adequacy and basically to lock in what's already there and to prevent it from vanishing. And if we take the suggestion to put it in more direct language, CMS can make the money go away, but I do not believe CMS can make the money come back. So we'd have to craft something that says -- this is where we struggled with the wording -- if CMS makes this go away, then Congress then has to step in and put the money back. That would be item number one.

But that step is the one that will get you to a word of about a 5 percent overall margin, which again, depending on your views, would be higher relative to say other facilities that you've considered today.

The second piece of this is a distributional component that says within that pool of money that's funding

an overall 5 percent margin, you've got a significant disparity between freestanding SNFs who are going to be somewhere in the 9 percent range and hospital-based SNFs who even after we take into account cost allocation would have margins on the minus 20 percent range. So an update of something on the order of market basket minus one, which might be consistent with a 5 percent overall margin, could then be distributed as no update to freestanding facilities, an adjustment to the base, and a market basket increase for the hospital-based facilities.

But it's two pieces here. One is to make sure the pool of money is appropriate. The other is to do a distributional issue analogous to what you did with hospitals.

MS. RAPHAEL: I wanted to make three points. First of all, I think our recommendation needs to start with reiterating something on the classification system. Because unless we deal with that and get an effective classification system, how are we ever going to get out of this bind? We're going to have to put Band-aids on the system until we somehow have something that's a credible way of classifying and measuring resource utilization. So I would like to

start with reiterating something in that vein.

And I don't remember now how complicated it is to do this, but actually we have managed to do classification systems for home health care. We managed to do one for rehab facilities. So this is something that seems to me to be doable, if the intensity and focus is on it.

Secondly, on the issue of total margins, and we said earlier that we want to look at that through the filter of access. In your text you refer to one access study, and only one, which I believe was the OIG study of access. Or two of them.

But basically, I'm interested in what we know about access. I think I remember, and I'm not sure I got this right, that in general there was a sense that patients could be placed except for about 1 to 5 percent. But I want to know who's in that 1 to 5 percent, because I think we need to look at who might be the ones who were having some access issues.

And thirdly, I'm interested in this notion of what the different product is in hospital-based facilities. I understand the case-mix difference. It seems to me that for product we're using a proxy of more staff. I mean, that's

what I gather. But I'd like to better understand exactly what we think the product is that's different in a hospital-based facility from your average freestanding facility.

And one last comment, I also was wondering if you had any observations about the extent to which hospitals might be exiting this business, as they're exiting physician practice business, as they're exiting home health care, not only because of what happens in this particular business but because they have to focus more on what they consider their core business in a much more turbulent and difficult environment. And therefore, they're shedding what they consider less than central to their current business imperatives.

DR. KAPLAN: Let me address your questions. First of all, I agree with you that we should reiterate the recommendation on classification system.

As far as the difficulty of doing classification system, CMS was mandated by BIPA to study alternative classification systems for the skilled nursing facilities and report on them to the Congress in January 2005. CMS plans to do that, but there doesn't seem to be any sense of urgency in getting a new classification system, first of

all. I would say that yes, they have done other classification systems, but there's been will to do that.

Then the issue about a different product. Let me just say that we considered that there is a different product, that half the length of stay and almost double the skilled nursing in the hospitals compared to the freestanding SNFs. In this 10 percent that we are adding to the hospital-based, we really did not consider an addition for product. That 10 percent is more related to the case-mix different, those 11 points difference in case-mix.

So yes, we considered that there appeared to be a difference in product, but we didn't necessarily give them the money to cover a different product.

As far as the OIG studies, they really are the only access studies out there. But they are pretty decent studies. They talked to the discharge planners which, since all SNF patients are post-hospital, that would be the logical person to talk to.

You were right that 1 to 5 percent had difficult placing patients and that these patients were the most costly patients. I think that this goes directly back to the case-mix and the fact that you have people who are using

a lot of non-therapy ancillaries, as they're called, the non-rehab ancillaries. And that even that 20 percent bump that was given those medically complex patients did not really compensate SNFs for those patients. And so they were unwilling to take them.

Does that answer all your questions?

MS. RAPHAEL: Except the only other thing I was just wondering, do we know anything at all about the motivation of the hospitals existing the business? Because I think that's a very important number and we need to understand what's the reason for hospitals existing and to what extent are they exiting all supposedly non-core businesses. I mean, I know hospitals might define that differently. And to what extent is it really due to what they think is inadequate payment.

DR. ROSS: Carol, there's also a lot of other payment policies that have changed. For example, the transfer policy being the big one.

DR. KAPLAN: I can't answer your question. I think that would be a really interesting study to do, but I'm not really sure that when we come down to prioritizing staff's time that it really is something that you'd want to

do in the future. If it's something you think is really important to investigate, but I don't think we really do have any idea.

DR. NEWHOUSE: Since I assume you're going to bring us back language to look at tomorrow, let me suggest that we split this recommendation into two and that it go along the lines that Murray said, which I think is a relatively clear statement that the first recommendation deal with the total dollars in the system and the necessity for add-on Z, which we would spell out as the specific add-on needs to stay.

And then the second recommendation deal with the distribution between freestanding and hospital-based facilities. I think we've just tried to pack too much in here, in addition to a lot of code words.

I wanted to comment also on a substantive point about total margins and Medicaid deficiency. I agree with your point, Sally, about if Medicare puts more money in the states may pull it out. In addition to that, am I not right that the Medicare shares averages around 12 percent?

DR. KAPLAN: That's correct.

DR. NEWHOUSE: Then it's sort of, the Medicare

tail can't wag the Medicaid dog. I mean, if we're trying to make even minus 2 percent back to zero, we're talking about a 16 percentage point increase in the Medicare margin. That doesn't seem to be in the cards, in addition to all the distortions that would cause. I think that's not a fruitful line to pursue.

DR. STOWERS: I was just going to echo, I think the number one part about Z needs to be separated out. But I think to be consistent with our previous recommendations, rather than say freeze the base payment amount for freestanding, we'd be better to say for freestanding skilled nursing facilities a market basket update or whatever is not necessary. Saying that we're going to freeze it is different from what we did with the dialysis.

And then just take the last part for hospital-based and say we need a 10 percent increase in the base plus market basket and that's it. But if we're going to be consistent, instead of saying freeze, that has that permanent connotation to it again.

DR. ROWE: Can I ask just a technical question? When we're talking about -- I guess it's relevant to hospitals but moreso here because more of these are for-

profit. When w talk about these margins, are these pre-tax or after tax?

DR. KAPLAN: Pre, I believe. Boy, I'm trying to remember the cost report. I believe it has to be pre, but I can hopefully come back with that tomorrow morning.

DR. ROSS: In a minus 2 percent world, it's not clear what the issue is.

DR. ROWE: No, but in a 9 percent world before tax is 5 percent after tax, and it's just a different number. We have this illusory corridor that we think is the right comfortable corridor, and we were talking about sustaining financial stability and creditworthiness, et cetera. What is, in fact, the profitability? I just wondered whether these are before or after tax numbers, because it makes a big difference.

MR. HACKBARTH: Sally, I think we're done for today. How do you feel about that?

DR. KAPLAN: Thank you very much.

MR. HACKBARTH: So I think the bottom line is there seems to be agreement on the content but concern about the structure of the recommendation.

DR. KAPLAN: Okay, and I'll come back tomorrow

morning with revised recommendations.

MR. HACKBARTH: Thank you. The last item for today is home health services. Sharon?

MS. BEE: This presentation is primarily a discussion of the draft recommendations following just a brief review of the analysis that we've done.

First, I'll discuss the background for this sector, which I've repackaged in response to your direction from the last meeting, to emphasize the somewhat wild ride that home health has had over the last 15 years. Next, I'll review market conditions that we've been discussing for the last couple of months. And finally, we'll look at some more draft recommendations.

From 1987 to 1999 there was a rapid rise in use. For this sector, spending grew from $2 billion to $17 billion. The growth was driven by weak incentives for cost containment and the increasingly long-term care nature of the services delivered.

This growth prompted Congress and the administration, in the mid-90s, to take action to rein in home health. They implemented a series of new policies. The payment system was changed from the cost-based system to

the interim payment system in 1997. Then it was changed again from the interim payment system to the prospective payment system in 2000.

During this time, eligibility also changed somewhat. Beneficiaries whose only skilled care need was the drawing of blood no longer qualified for the benefit. Also during this time Operation Restore Trust was initiated to reduce fraud and abuse.

In the wake of these changes came a dramatic decline in use and spending. Spending fell by half from 1997 to 1999, reflecting a decline in both the proportion of beneficiaries using home health and the amount of services home health recipients were using.

Given the recent changes and a somewhat bumpy ride for this sector, payment stability for 2003 may be appropriate. By 2000, the intent of the changes made in the mid-90s seems to have been substantially met. Both beneficiaries and providers could benefit from allowing the system to settle down for a period.

Why here? Well, current market conditions provide no evidence of disparity between payments and costs. Entry and exit in this relatively fluid sector have been stable

for the last two years. Reports on access to home health services for beneficiaries from hospitals, nursing homes and the community all seem to indicate good access.

And lastly, without a clear definition of the benefit and clinical standards, we have a limited ability to interpret the changes in use that we can observe.

Which brings us rather quickly to our draft recommendations. As a theme for all three of these recommendations we have a mix of what we know and what we do not know. There are two versions of draft recommendation one on the screen for your consideration.

As a matter of commission policy, and to be consistent with our analytic framework, you could recommend an update equal to the forecasted increase in input prices in the absence of compelling evidence that costs would change at some other rate. However, we note that the uncertainty in this sector is far greater than the other sectors. We have no useful data about costs under this PPS.

Given the high level of uncertainty, there's no evidence that endorsing the update in current law of market basket minus 1.1, rather than introducing yet another change, is inappropriate.

Draft recommendation two addresses the so-called 15 percent cut. You could recommend the elimination of the cut. This would suggest that the work of the BBA's changes in the mid-1990s is substantially done. We would make future corrections to payments through our update process. Eliminating the cut removes the uncertainty about its implementation and allows policymakers and providers alike a better idea of what's coming for payments in this sector for the future.

We could recommend postponing the cut. We've suggested in this draft recommendation a two-year postponement in response to your input from the last meeting. We will not know much more about the fundamental questions of payment adequacy at this time next year. Postponement would allow time to receive and analyze some cost data from the PPS. It avoids shock to the system of implementing the cut and maintains a tool to reduce spending substantially if appropriate. However, the postponement prolongs the uncertainty of the cut.

Draft recommendation three. As we've discussed in past meetings, we do not have evidence that rural access currently is impaired. In the OIG's study, hospital

discharge planners had no greater difficulty placing beneficiaries in home health than their urban counterparts. However, use declined significantly more quickly in rural areas than in urban from 1997 to 1999 and the proportion of exiting agencies in rural areas was greater than urban. Given the uncertainty, a time limited extension of the rural add-on payment may be appropriate.

With that brief discussion, we can open up input for the draft recommendations. Any questions?

MR. HACKBARTH: The crux of the problem here is we don't have cost information, the benefit is ill-defined, there are not clinical standards as to appropriateness, and so we're cut loose from all of our usual moorings and just sort of bobbing about on the sea.

MS. BEE: In our new analytical framework what we've done is we've tried to give ourselves new tools other than margins, other than just relying on some of the cost and the payment data. And we have looked at those. While I wouldn't describe us as on the most solid ground, we have some footing here.

MR. HACKBARTH: Fair enough. I stand corrected. So at least we can say there isn't any gross evidence of

access problems, but that's all we can say at this point.

MS. RAPHAEL: We do know about exit and entry because that's as I recall during cost base there were three new entrants for every departure. And then, when we went to IPS there were eight who left for every one who came in. And now it's pretty stable, at about 7,000.

DR. NELSON: Do either you, or perhaps Carol, know how many areas are down to a single home health provider and which choices formerly were present? Perhaps choices that might be more cost efficient or convenient for the patient.

MS. BEE: We're a little limited in our ability to interpret the data there. GAO did a study to look at the question of the availability of providers. We're always a little bit limited in this area because our official numbers count parents and not branches. So there could very well be a branch of an agency and we would not be aware of it from the way we count their heads.

When GAO looked at the issue for rural areas, especially where you might be concerned about a single agency, in a very high proportion of the counties that our data indicated had zero or no agencies, they found up to three serving the county.

The service areas of the agencies are not very well defined again by our data, so it's very difficult for us to know where that situation might exist.

DR. REISCHAUER: Sharon, just the information you've provided us and a desire to be prudent I think would suggest that we go with the full market basket.

I also would be opposed to postponing the 15 percent cut for two years because I don't think there's any indication at all that we're, in a sense, overpaying by something close to 15 or 10 percent. We'd see expansion in the industry. We'd see something going on.

I mean, we might not be right on, but we can take care of that two years from now when we look and say are payments adequate in the base and make a little adjustment there, rather than holding out this threatened club for another two years. So I would go full market basket and the first half of recommendation two.

MR. FEEZOR: I guess I was going to ask a question that Bob's recommendation would make moot. Is there any indication what a 15 percent reduction would do to access? I guess that's the question I'd have.

DR. ROSS: Sharon, would you first clarify that

it's not really 15 percent. We use that because that's what's in law, but it is not numerically 15 percent.

MS. BEE: Our best estimate is that the actual reduction would be between 6 and 8 percent reduction to the base.

MR. FEEZOR: Do you have any indication what impact that will have or would have?

MS. BEE: I don't know.

DR. WAKEFIELD: I agree with Bob and Allen -- I think Allen was agreeing with Bob -- with regard to the first two recommendations, and I'd like to comment on the last. That is the extension of the 10 percent rural add-on payment for two years. A couple of comments about that.

First of all, in our June report, I think that some of what we said there was I believe similar to what you've just said. That is, we have a lack of data, there's a need for data collection and analysis to see what's really going on with those facilities. And we still don't have that data. Or if we've got it, I missed it. Or we don't have much of it. So that need, I believe, still exists.

Secondly, I'm a little concerned about what those beneficiaries are getting in rural facilities. When I went

back and looked at that section of our June report, it said for example that even when you have similarities in diagnosis and functional status between urban beneficiaries and rural beneficiaries, what rural beneficiaries are getting is not the same service as their urban counterparts. And that in fact, it seemed that if those rural beneficiaries were geographically located in urban areas they would, on average, be getting those more intense services. So in other words, if you looked at the population that had no differences in diagnosis or functional status, the level of intensity of services already is different.

Now one might say maybe the beneficiaries in urban areas are getting too much service, or more service than they need. But the point is there is a difference, even when you hold constant diagnosis and functional status. So there's something going on there that I don't know that we fully understand.

The last point I wanted to make about that particular recommendation is that, as you indicated, we've got a very significant more rapid decline in proportion of beneficiaries using home health in rural areas than in urban

areas. And that the rate of exit of agencies in rural areas is proportionately much greater than their urban counterparts. But we counter that in the text with GAO's finding that there doesn't seem to be a problem with placing Medicare beneficiaries in either rural or urban areas.

So I guess what I might say that that might suggest is that 10 percent -- because I don't know that we know any better -- that 10 percent rural add-on, in fact, might be just about right. Clearly, the trend in rural areas doesn't seem to be with that 10 percent add-on driving increased utilization. So it may be that -- although again, we don't have much data to work with here, but it seems to suggest that maybe that 10 percent is supporting some adequate access or ability to place Medicare beneficiaries in home health. Or maybe they're getting their home health services at a great distance from where they live. We don't know.

So there's just a lot we don't know here and clearly there have been huge shifts, especially in rural home health. So it's a concern to me, in terms of access for rural beneficiaries.

MR. HACKBARTH: Are we ready to move to voting?

MS. BURKE: I just have one. Just following up on Bob's point about the second recommendation regarding the payment cut. I was just going back through the text again.

As I recall having read the text of the report, it repeatedly stated throughout there was no indication that there was an overpayment, that the payment was too high. At least, that's how I read this. Am I misreading what you said?

Basically, first of all, you said we don't know very much. Then you went on to say that what we know is that we don't believe, given what we know, that the payments are not appropriate. I believe you specifically say, when you talk about the payments to cost. You talk about volume and what's happened in terms of the frequency of visits which have continued to decline a bit, not certain why, not certain whether quality has been affected. The entry and exit seems to be relatively stable. Your comment, at one point, in discussing the recommendations are that these folks have gone through a series of seismic changes in the last few years, which we may or may not want to have more seismic changes occur.

But I wonder, having said all of that, Bob's point

about let's just go ahead with the scheduled reduction seems to fly in the face of the content. Or not?

Oh, I thought you said to go ahead.

DR. REISCHAUER: No, I said eliminate it permanently.

MS. BURKE: Never mind. We're in the same place. I thought you said to go ahead, I'm sorry.

For that reason, I support everything Bob has just said.

MR. HACKBARTH: I think we're ready to vote. What I'm going to suggest is that we follow Bob's lead and vote on the first draft recommendation one. Are people okay with that?

The recommendation on the table is Congress should update home health payments by market basket for fiscal 2003.

All opposed?

All in favor?

Abstain?

On draft recommendation two, again we'll go with the first alternative. The Congress should eliminate the payment cut scheduled for October 2002 in current law.

All opposed?

All in favor?

Abstain?

And draft recommendation three, Congress should extend the 10 percent rural add-on for two years.

All opposed?

All in favor?

Abstain?

Okay, thank you Sharon.

MS. NEWPORT: Murray and I had a brief sidebar here about what all of this will cost when you add it all up. What it means for me at least, the question has more to do with what the Congressional process is and how CBO will score this. I guess we'll know more about that next week.

I was wondering if perhaps the staff could share with us, once we have that, what this means in real money. I'm just interested from a lot of standpoints, in terms of how it affects overall payment.

DR. ROSS: We'll try to get you what I can. My remark about baselines was some of these things -- I suspect, for example, the physician fee recommendation will cost something different in two weeks on the budget

scorecard than it would cost today.

I honestly don't know on the issue of the SNF payment because I don't know what is being assumed in baseline about whether CMS will or will not eliminate that money -- excuse me, propose the refinement.

MS. NEWPORT: To the extent that you can reasonably give us a report on that, I think that would be helpful.

DR. NELSON: It isn't so much new money. A lot of this is restoration of old money.

DR. ROSS: That's not how it gets scored.

MS. NEWPORT: I would agree with you in some respects.

MR. HACKBARTH: It's now time for public comment. Let me remind people of the ground rules, for those of you who weren't here this morning. We'd ask you not to read written statements. Please keep your statement brief. And if we find that people from the same field are repeating comments, I'm going to reserve the right to cut off the conversation so that as many people as possible can get to the microphone.

MR. CHINCHINAO: Thank you. I'm Dolph Chinchinao,

representing the National Kidney Foundation. We wish to thank the Commissioners for their recommendation for a dialysis rate update and use this opportunity to highlight some of the changes in the demographics of the dialysis population since the composite rate was introduced in 1983.

In 1984, 7 percent of the dialysis population was over 75 years of age. In 1999, that had doubled to 14 percent of the prevalent ESRD population over 75 years of age. And that segment continues to be the fastest growing part of the population.

Secondly, the percentage of patients who came to dialysis in 1984 because of diabetes as the primary cause of kidney failure was about 16 percent. By 1999 that also had doubled to 33 percent. We are convinced that the recommended update will ensure that these older and sicker patients receive the kind of services that they need.

Thanks again.

MS. NAZACK: I'm Susan Paul Nazack with the American Association of Homes and Services for the Aging. We represent the non-profit continuum of long-term care that includes nursing homes, skilled nursing homes, both hospital-based and freestanding.

We applaud the fact that there is a recommendation to keep what I'll call the Z again, in the base because we certainly do need to keep the money there. However, the concern with the access for medically complex residents. These are people who have a variety of different cases. They have non-therapy ancillary costs that far exceed the average payment. If we only provide additional monies to the hospital-based, then the freestanding that are also taking care of the medically complex patients are going to be at a tremendous disadvantage and could really hurt access.

Virtually all SNFs serve some medically complex patients. However, the residents who utilize non-therapy ancillary costs that greatly exceed the payment can be found probably in all RUG groups, but they have a great probability in being in the RUG groups for the extensive services. It is not unusual to have non-therapy ancillary costs of $700 a day. This is for skilled nursing facilities that are freestanding, as well as the hospital-based.

Patients categorized in the extensive services have IV medication, suctioning, tracheotomy, ventilation service, IV feeding. These people are very sick and they

need to have services.

The access problems that have been identified in the past, though they've not been totally identified, are primarily these type of patients and these are the ones that are going to be having even harder services if the freestanding do not get an added amount that could help compensate.

Thank you.

MR. LANE: Larry Lane, Genesis Health Ventures.

A couple of points. Pete asked, in some sense, what are we talking about in magnitude? X is about $500 million. Y is about $0.9 billion or about $900 million. Z is about $1.2 billion for a total component of $2.6 billion. The market basket change proposed is about $400 million.

The Commission recommendation discussed today takes $1.8 billion out of the skilled nursing sector. And the real question the Commission has to address is can that sector absorb that impact? It translates, if I heard Sally correctly, the minus 2 percent margin, this translates into a margin impact negatively of approximately 4 to 5 percent.

The question really begins to be if you throw the anchor into the middle of the boat rather than in the water,

who is going to take care of mama?

The margin analysis must say must be done in the context of admission discharge was not discussed that way and we've given staff an analysis done using CMS claims file analysis that tracks admission and discharges '94 through 2000. And it will point out very simply that there's 100,000 fewer beneficiaries served in '99 than '98 by skilled nursing facilities. It also points out that approximately 82 percent of the admissions and discharges are in the freestanding side. So a lot of attention is being given to the hospital-based component.

The third is is that hospital-based component different? And I will add to materials I have given staff a study that we've just gotten today from Curry Kilpatrick out of the University of North Carolina, and Bill Roper was engaged in this. I'd just read two points in the total regression analysis that they did.

One, our analysis showed no substantial differences in the capability to the level of care that is offered by freestanding versus hospital-based SNFs.

Two, we found no evidence to support that the PPS or BBRA had a differential effect on hospital-based facility

compared to freestanding SNFs.

I must say while APR DRGs is a novel idea, it is not the basis for the payment structure that is in place today in the case-mix index. And when hospital-based versus freestanding are analyzed using that index, what comes up is it is not the setting that is the difference. The real question is are we going to redo what was old policy? That was reward hospitals for their inefficiency. Or are we attempting to try to drive an efficient care delivery structure.

Thank you and we'll continue to talk with you, I guess, over the next coming weeks.

MS. FISHER: Thank you. Karen Fisher with the Association of American Medical Colleges.

I want to take us back, I apologize, to hospitals. We appreciate the fact that it seemed this morning that the Commissions thought that total margins would be a useful piece of information to have when looking at updates in financial performance. Given that, I think it might have been helpful in this afternoon's discussion if total margins were part of that discussion. Unfortunately, they weren't.

If you look at the total margins that Craig

presented, unfortunately I don't think it was not presented today total margins for large urban hospitals. But let's, for the moment, assume somewhat of a proxy with major teaching hospitals. If we assume that what was presented for major teaching was 2.4 percent, then if you look at the analyses by the staff of taking the 1998 overall Medicare margin and the staff doing its best efforts to increase that to 2002, there's obviously a decrease in overall Medicare margins between those three years by 2 percentage points, 2.1 percentage points.

Assuming private payers' behavior remains the same, that's going to mean a reduction in the total margins for those institutions that could be almost up to 1 percentage point.

You then factor in the fact that for these institutions you're not going to give a full market basket update but market basket minus 0.55 percent, you start to bring the total margins for these institutions possibly dangerously close down to one. And that's assuming private payer behavior stays the same.

I would hope that given the Commission's discussion this morning about the value of total margins

that the estimates that are used for Medicare, et cetera, can be expanded to total margins and at least brought forth for the Commission to have that discussion and have that information before them when they make their decisions.

Thank you.

MR. PYLES: My name is Jim Pyles. I'm here on behalf of the American Association for Home Care.

I just wanted to commend the Commission for the recommendations, all three recommendations with respect to home health. The recommendation particularly with respect to the elimination of the 15 percent cut, I think finally puts home health on the path to a rational reimbursement system and one that can be refined in the future to meet the clinical needs of the patient.

I would just ask you though, as you go forward with further deliberations on home health, to remember there were 1 million Medicare beneficiaries eliminated from the home health benefit over a two year period. That's a fourth of the beneficiary population. We know from GAO studies and from MedPAC analyses that the greatest reductions were among the highest utilizers in the patients in the rural areas. We believe those are the most vulnerable patients. We

believe there has to be and is an access problem among those patients who cannot have that degree of reduction or elimination of patients from a benefit without their being an access issue. And we know that there are many rural areas across the country that are either down to their only home health agency left or they've lost the one home health agency they had.

We hope in the future that you'll look at home health not in isolation to determine whether it's growing too fast or too slowly, but to look at it as a tool for addressing the need to provide more services for less dollars.

Thanks very much.

AUDIENCE SPEAKER: I'll obey the rules and I won't repeat everything that my colleagues in long-term care have said before, in Larry Lane and Susan Paul Nazack.

But I would plead with you to pay special attention to some of the points that Susan made because I think there is a very critical issue here. That is do you believe that there is an access problem for skilled nursing facilities? Or do you believe there is not an access problem for SNFs?

Today Commissioner Reischauer said the following: Preservation of facilities should not be an objective unless preserving access. If there is no access problem then it is difficult to follow the logic of distinguishing between the hospital-based SNFs and the freestanding SNFs. But if there is an access problem, and we have believed for a long time, with the American Association of Homes and Services for the Aging that there may indeed be an access problem for the very, very acute patient, the patient with very high acuity.

And therefore, the important thing is to get that patient both into a hospital-based SNF and into freestanding SNFs. Because that patient may actually be backing up in the acute part of the hospital itself.

So I would ask that you, if possible, revisit the issue of the freestanding versus the hospital-based SNF. Along those lines, you might even ask, as Commissioner Raphael did, what are the basis of those hospital costs that make them so high in the hospital-based SNF? They can't possibly be entirely due to the issue of acuity.

And last but not least, the question about the product. I won't question that perhaps the length of stay is about half, and perhaps there are more RNs, but where

does the hospital-based patient go when he or she leaves the hospital-based SNF? Is it to hospital-based home health care? Is it to home health care period? Or is it to freestanding SNFs?

We do not have the data but if memory serves me correctly, I think even MedPAC a couple of years ago looked at that issue. You might try to find that data and see if indeed quite a few of those patients crossover to freestanding SNFs.

Thank you.

MR. HACKBARTH: Okay, we are adjourned until 8:30 tomorrow morning.

[Whereupon, at 5:22 p.m., the meeting was recessed, to reconvene at 8:30 a.m., Thursday, January 17, 2002.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, January 17, 2002
8:33 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Good morning. Welcome. First on our agenda for today is what's next for Medicare+Choice. Scott, are you leading?

DR. HARRISON: I guess so. Today we plan to briefly review our conversation from last month to make sure staff understands the Commission's decisions. Dan will give an up to the minute update on CMS' risk adjustment work. I will then go over the thrust of the draft chapter that staff have prepared for you. We've also prepared a couple of draft recommendations for your consideration. Finally, Ariel will present a table to help clarify our discussion of the GME carve-out discussion.

The Commission, as it recommended last year, is strongly in favor of moving to a payment system where the Medicare program will be financially neutral between its expected payments on behalf of beneficiaries in the traditional program and enrollees in the Medicare+Choice plans. The payment comparison would be made at the local market level. This policy could be operationalized by setting Medicare+Choice payment rates equal to 100 percent of the expected local area per capita risk adjusted spending

under the traditional program.

The Commission also reaffirmed that risk adjustment is a crucial component of a financially neutral payment policy. A payment policy cannot be financially neutral if there's not an adequate risk adjustment system in place. And Dan will now discuss what CMS is doing on that.

DR. ZABINSKI: First of all just a quick overview and some background on what CMS had planned is that it thought to implement a multiple site risk adjustment model that uses all diagnosis from hospital inpatient, hospital outpatient, and physician office encounters and they intended to begin using that in January 2004. But the plans complained about the burden of the plan data collection system. So last May the Secretary suspended collection of full encounter data from ambulatory sites.

In response, CMS is now developing a multiple site system that uses diagnosis from inpatient and ambulatory sites of care but would put less burden on plans to collect and submit the data. CMS yesterday had a public meeting to discuss the status of that effort. No final decision has been made and the meeting covered reducing the data collection burden in models that CMS is considering.

To reduce the data collection burden, CMS first of all is decreasing the number of data elements that plans must submit. The initial data collection required plans to submit information that would have made auditing easier and would have allowed CMS eventual use of encounter data to calibrate the risk adjustment model.

But many of those variables are not necessary to run a risk adjustment model. The only variables that plans will now have to submit are simply beneficiaries' ID, diagnosis codes, beginning and ending dates for a particular service, type of bill such as inpatient, outpatient, or physician office, and possibly an indicator of the principal inpatient diagnosis.

CMS is further decreasing burden by reducing the number of diagnoses that it will use to risk adjust payments. Consequently, plans only have to submit those diagnoses that will result in higher payments although they may submit as many diagnoses as they want. If a diagnosis does not result in a higher payment they can submit those as well if that's easier for them to submit a whole batch. Also plans will only have to submit data quarterly rather than monthly, and they only have to submit conditions

triggering higher payment once each annual reporting period rather than repeatedly like they currently do.

Now the multiple site models that CMS is considering fall into three general categories. First of all, CMS might use one of the multiple site risk adjustment models it had under consideration before data collection was suspended, such as the hierarchical condition category model, but they would use fewer diagnoses than a full model. The number of categories that they would use could be as few as six or as many as 100, but 100 has been determined to include all the categories that are significant in terms of predicting cost.

CMS has to decide how many categories to use and which ones to include in the eventual model. It also has to consider the conflicting issues that, first of all, more conditions would improve predictive power, but then it would also increase data collection burden.

In any event, all diagnosis categories selected for use would be filled with diagnoses from both inpatient and ambulatory encounters, and payment for a condition would be the same whether a diagnosis is inpatient or ambulatory.

A second option CMS is considering is once again

using a multiple site model under consideration before data collection was suspended but first of all include only the 100 significant diagnosis categories I mentioned earlier and fill most of those with only diagnosis from inpatient encounters. A few selected additional categories would be also filled with ambulatory diagnosis. In categories that would use both inpatient and ambulatory data -- I'm not certain about this but I believe the idea is that the payment rates would depend upon site of care. The payment rate would differ if it's an inpatient or an ambulatory diagnosis.

Finally, CMS is considering the current PIP DCG model; that is, the inpatient-only model, but would then add some diagnosis categories for some ambulatory diagnoses. Once again, I believe the payment rate would depend on site of care.

Finally, CMS released some important dates I think we should pay attention to. First of all it will announce which diagnosis will trigger higher payments in whatever model they eventually decide to use on March 29, 2002. Plans will begin collecting diagnosis information on July 1st, 2002. CMS will announce which multiple site model it

will use on January 15th, 2003, and then they will begin using the model on January 1st, 2004.

DR. HARRISON: Last time we also discussed the carve-out of payments to teaching hospitals for GME cost from the calculation of Medicare+Choice rates. The Commission believed that the carve-out policy provides incentives for plans to contract with teaching hospitals. At the end of our presentation today Ariel will go over a table that shows some examples of what we might expect to happen under a financially neutral payment system with a carve-out.

We also discussed that the use of competitive bidding to set payment rates would introduce cost saving incentives and address some geographic equity issues. However, it would also introduce new equity concerns and cause redistribution of resources such that it would probably be very difficult to generate a political consensus to support it.

Now let's turn to the chapter draft. The first main point is that we want to move to a financially neutral payment system. We've covered why we're unhappy with the current system repeatedly and I don't really think you want

to hear me go through that again. We've also expressed strong support for the rapid development of an adequate risk adjustment system over the past few years and we want to stress that again in the chapter.

The last half of the chapter examines competitive bidding and how it might be used within a financially neutral payment system to address some of the remaining issues that we would have after moving to a system that sets rates at 100 percent of fee-for-service.

The three issues we look at are cost reduction, availability of plans, and geographic equity. A system that sets rates at 100 percent of risk adjusted fee-for-service payments is not designed to save money. In fact, unless the savings from risk adjustment were larger than the cost of the average increase in rates needed to reach 100 percent, then the system would result in a little added cost to the Medicare program. Because competitive bidding systems would treat fee-for-service spending as a rate ceiling however, competitive bidding would save money relative to setting rates at 100 percent of fee-for-service.

We also acknowledge that moving to a financially neutral payment system is unlikely to increase the

availability into currently low paid areas because those areas would usually end up with lower payment rates under financial neutrality since the floors would be eliminated under such a system. Competitive bidding would not help these areas get plans though because it would only result in lower payment rates. Thus it is unlikely that plans that would enter areas where they don't already exist.

The last remaining issue is equity. The financially neutral payment system was designed to address equity between beneficiaries in the traditional program and enrollees in Medicare+Choice plans within a local market. It would not address equity across geographic markets. Some see the current system, and a system that paid 100 percent of fee-for-service rates also, as equitable because all beneficiaries across the country can join the program by paying the same Part B premium. Others see it as inequitable because beneficiaries may have access to richer benefit packages depending on where they live. Paying 100 percent of fee-for-service would not change those equity considerations significantly.

Using competitive bidding to set rates would greatly change the equity consideration. First, the

entitlement would change from the traditional program to the benefits that are offered under the traditional program without being guaranteed the broad choice of providers that are available in the traditional program. While all beneficiaries across the country would be guaranteed the basic benefit package for a set national premium, beneficiaries would have to pay more to stay in the traditional program in some parts of the country.

Now compared with a system where payments are set at 100 percent of fee-for-service, the only way any beneficiaries would be better off is if the cost savings from competitive bidding were redistributed to all beneficiaries in the form of either lower Part B premiums or an improvement in the basic benefit package. This shows why people who were interested in competitive bidding thought that that couldn't happen without adding benefits at the same time and I think that just shows why.

That concludes the focus of the chapter. Ariel will -- actually we'll do the draft recommendations first.

The Secretary should ensure that an adequate risk adjuster is used to pay Medicare+Choice plans as soon as possible. This adjuster should not impose an undue burden

on plans and providers.

This is a slightly stronger statement than we made last year, but it's a requisite for recommendation two.

DR. ROWE: Can we discuss the recommendation?

DR. HARRISON: There's only two of them so you could discuss them at the same time.

MR. HACKBARTH: My thinking, just in the process was, let's get it all out on the table, including the draft recommendations, and then go back and discuss everything that's been put on the table.

DR. HARRISON: Then draft recommendation two is, When adequate risk adjustment is in place, the Congress should set risk adjusted payments to Medicare+Choice plans at 100 percent of per capita local fee-for-service spending.

So those are the two recommendations. Now we can go over the carve-out or discuss the recommendations now. Just go to the carve-out?

MR. HACKBARTH: Yes, get it all out and then we'll discuss --

MR. WINTER: This actually illustrates the impact of moving to financially neutral payment rates both with and without the carve-out. So essentially it illustrates the

last part of draft recommendation two, which is to set payments at 100 percent of per capita local fee-for-service spending.

We've picked some selected counties to use as examples. The first group of counties are those that received 2 percent updates in 2002, the second group are those that received the floor rates in 2002. The first column shows the current M+C rates. The second column shows local per capita fee-for-service costs in 2002. The third column shows per capita fee-for-service costs less GME and IME spending. This would be the base rate in a financially neutral payment system that removes those GME and IME payments. And the fourth column shows the GME and IME cost as a percent of local fee-for-service costs.

You'll notice that fee-for-service costs, the second column, are slightly higher than the payment rates in most counties, with the exception of Manhattan and Portland. Manhattan's rate is higher because its Medicare+Choice rate has grown faster than fee-for-service spending in that county. Portland's rate is higher because its floor rate far exceeds its fee-for-service spending.

When you remove GME and IME spending, which is the

third column, fee-for-service costs drop below M+C rates in 2002. The size of the decrease depends on the size of the carve-out. If you compare fee-for-service costs before and after the carve-out, Manhattan's fee-for-service costs fall by $90, because it has such a high GME percentage, and Los Angeles' costs drop by only $17 because it has a much smaller GME percentage. So we just present this to illustrate the impacts of a new financially neutral payment system.

With that we would open it up for discussion and take your questions.

MR. HACKBARTH: Could you explain Manhattan again, the first two columns?

MR. WINTER: Yes. What you have in the first column is its current M+C rate. The second column is its projected per capita fee-for-service costs in 2002. You're asking why it's lower?

We assume it's lower. We don't have all the data points for fee-for-service across Manhattan. We have '99 and we have its '97 AAPCC which actually reflects its average '91 to '95 costs. There's a decline from its '97 AAPCC to its '99 fee-for-service costs. That's somewhat

consistent with the decline in per capita fee-for-service costs across the entire program. Then we just project forward its '99 fee-for-service costs to 2002 using the change in national fee-for-service spending on a per capita basis. What we come out with is a slight decline from its 2002 rate.

But as you can see, the other counties that increase, the other 2 percent counties that have an increase are actually a slight increase over the current rates. So it's not a huge difference.

DR. ROWE: I apologize, but I don't understand how -- I thought there was a rule or something about it -- the M+C rate was some proportion, currently less than 100 percent of the fee-for-service rate. So if I could ask you to explain to me again where I'm wrong, and how we got --

MR. WINTER: Sure. The way it works is, we start out in the current M+C payment system, we start out using the 1997 AAPCC, which is theoretically 95 percent of local fee-for-service costs. However, there was a calculation error when they calculated those rates so that they're actually 98 percent of local fee-for-service costs. The BBA did not allow this calculation error to be corrected. So

that's what we start out with, it's about 98 percent of the fee-for-service costs in Manhattan.

Then each successive year the county is guaranteed the higher of a 2 percent increase over the '97 rates, a blended rate, or a floor rate. Now in Manhattan's case, it received a 2 percent increase over the prior year's rate in each year from '97 to 2002, because that was the highest of the floor and the blend rate. Now that 2 percent annual increase exceeded the growth in local fee-for-service costs in Manhattan.

We find that spending declined between '97 and '99. We don't know actually what spending looks like in Manhattan in years after that but we've just assumed that it follows the national trend.

DR. ROWE: I understand. So then you're recommending -- we can get to the recommendations, but just so I understand, you would be recommending then that the M+C rate in Manhattan be reduced --

MR. WINTER: That's the logical conclusion from --

DR. ROWE: because you're recommending 100 percent of the per capita fee-for-service costs.

MR. WINTER: Right. What the Commission has said

at the last meeting where we talked about the GME and IME carve-out is that those payments should be removed from local fee-for-service costs when calculating payment rates. So therefore, that leaves us with a third column as the most likely base rates in the Commission's recommended payment system.

DR. ROWE: Even forgetting the GME carve-out, 795 is higher than 760.

MR. WINTER: That's right.

DR. ROWE: Because we kind of got into this discussion about how can we fix the M+C program, and your recommendation is that we reduce the payment rate.

MR. HACKBARTH: But, Jack, it's easy to imagine a scenario under which if our recommendation were adopted that the M+C rate would not be lower. Our goal is to have the M+C rate equal to 100 percent of underlying fee-for-service costs. If we stay with the current system and they're constrained by the 2 percent increase and fee-for-service costs start going up by more than 2 percent --

DR. ROWE: I'm well aware --

MR. HACKBARTH: -- then you would find that HMOs in Manhattan would benefit from our proposals.

DR. ROWE: I'm very familiar with that problem.

MR. HACKBARTH: So this is a temporary --

DR. ROWE: Okay, I just want to make sure I understand what --

MR. WINTER: This is a snapshot, 2002.

DR. REISCHAUER: But also, if per capita fee-for-service spending in Manhattan had grown, after the two years of decline, at 7 percent, as Jack probably suspects it has, then there would be an increase. This is really your general assumption that Manhattan was like the nation as a whole.

MR. WINTER: That's correct.

DR. REISCHAUER: It may be, but maybe not. But certainly over the long run, Jack, it's not going to come out the way you --

DR. ROWE: I understand. I just want to make sure I understand how we got here. Is this Portland, Maine or Portland, Oregon?

MR. WINTER: It's Portland, Oregon; Multnomah County.

DR. REISCHAUER: On draft recommendation one, I realize that it is sort of a preamble for number two, but it

sort of is like, we think the Secretary should follow the policy he's already following, isn't it?

DR. HARRISON: Yes. One danger though of only doing two is that people might forget to do one, say in the legislative proposals that might be coming out. Now the question is, I guess, whether you think everything is on track, and if it is then there's not a problem.

DR. REISCHAUER: Maybe you can put it all in the text as opposed to in a recommendation. But it strikes me as stupid when we --

MR. HACKBARTH: The first clause of recommendation two makes explicit reference to having an adequate risk adjustment as the necessary prior step. So it seems a bit redundant to me, also, to make recommendation one.

DR. ROWE: Can we talk about the adequacy issue? We have a term there, adequate, and I assume that the cognoscenti with respect to risk adjustment must have therefore some proportion of the variance that is described by it that meets that criterion. I mean, what's adequate?

DR. NEWHOUSE: Nobody knows.

MR. HACKBARTH: It would be helpful to me if at least we could better understand how CMS is evaluating the

trade-offs. There is at least one obvious trade-off between predictive power and burden on the plans. How are they thinking about that issue?

DR. ZABINSKI: They gave no indication yesterday of how they're thinking about that issue. I know they're concerned. Their two concerns are, first of all, predictive power, and second of all, data collection burden, and they're trying to balance the two.

DR. ROWE: Did they describe the proportion of the variance, or the predictive power of the different models that --

DR. ZABINSKI: Yes. I think the lowest they had would be about 7.5 percent and the highest I think was 11/5 percent. For example, they include -- like I said earlier, they'll include as few as six diagnoses and as many as 100. If they include only six it's 7.5 percent variation. If they include 100 it will be 11.5 percent.

MR. HACKBARTH: To this point they have not said, we don't feel we can go below X percent and still be adequate.

DR. NEWHOUSE: Scientifically we just don't know. What we know is that if you explained everything that was

predictable you'd be somewhere north of probably 25 percent. But we don't know how far short of that you would have to be before you'd have a tolerably good risk adjuster. I mean, you're never going to be perfect, but in the real world you don't have to be perfect. We just don't know how good you have to be, because all our observations are down in the range of you explain 1 percent or so. We know that doesn't work. Beyond that we just don't know how well you'll do.

DR. ROWE: What term should we use in the recommendation? You write papers and do research in this area. What would we use?

DR. NEWHOUSE: I don't have a better one, off the top.

MR. HACKBARTH: Joe, I agree completely with your point but a decision needs to be made, and you can either have an implicit standard of what constitutes adequacy or an explicit standard. So my question was, how are they going to make the decision? Are they just going to mumble, we think this is right, or are they going to say, here's how we think about it?

DR. NEWHOUSE: I think it will presumably be a trial and error process. We'll put something in place and

see how much selection is observed. Then if we think that's too much we'll try to do something else, although it's not totally clear where we get anywhere near as big an increment as we're going to get from diagnosis.

DR. REISCHAUER: I think the term adequate means a risk adjuster which makes it inefficient for plans to invest in activities to attract low risk people. So it depends very much on the behavior of plans. Then you can substitute regulation, penalties, whatever for risk adjuster as well.

DR. ROWE: I understand.

DR. ROSS: Can I offer just a clarifying point? CMS has implicitly set an upper bound in terms of what it considers in announcing a suspension of the current system. That reflects a judgment that the data collection costs there were too high in return for the variation in resources that was being explained. Although as I recall when that suspension was announced it was, we'll look and see if we can come up with something better; i.e., lower cost with similar explanatory power. But that was their judgment that that was too much burden and not enough power.

DR. ROWE: I guess my concern in the real world here is two things. One is that the Medicare+Choice program

is not prospering and there is a lot of concern in Congress and elsewhere about trying to do something to bolster it, or save it, and revise it, or strengthen it, turn it around, et cetera. What we're recommending, which is going to 100 percent of the fee-for-service, is likely to have a modest positive effect in that direction. Not dramatic, as you can see from the figures. Modest, but nonetheless positive, with the possible exception with a couple of idiosyncratic places.

But we are tethering that to the implementation of this risk adjuster and we have now been told this morning that that will not be started until January of '04. It seems to me that the perfect might be driving out the good here, and that an additional two years under the current system before the payment rate is adjusted to 100 percent, because we don't want to do that without explaining this additional five or six or 7 percent of the variance -- and I understand the reason for that -- might be too late. It just might be too little, too late.

It's academically understandable how we might want to link those two things, but from a policy point of view I'm not certain that it makes sense. So I think I'd be

interested in what commissioners think about it.

DR. REISCHAUER: I was going to say, we don't know, if we had a level playing field, whether Medicare+Choice is a viable entity. In the sense that we have on one side the fee-for-service system which is the mother of all price discounters, and on the other side a method of providing services that has an unattractive aspect to some beneficiaries in that it restricts choice. If you pay them both the same, the plans have to cover marketing profit, higher administrative costs, and provide something to entice beneficiaries to join.

Without the kind of formulation that Scott has put forward where in the areas where these plans are more efficient and provide the same services but in a different framework cheaper, and you charge people more if they want to change in fee-for-service -- without going to something like that you don't know, if we level the playing field, five years from now there will be really very few plans left in America.

DR. ROWE: I accept that, Bob, but I think we don't know. It might strengthen the program. It might not be enough. But what about my concern about the fact that

during this interval period of -- perhaps critical period for the future, that perhaps it's not appropriate to delay two years before we level the playing field, just so we could have the advantage of the coincident modest increase in variance explained by the risk adjustment. That's my --

MR. HACKBARTH: Jack, the reason that we link the two was that there is a lot of research suggesting that currently we're overpaying the plans because of preferential risk selection. If in fact that's the case, going up to 100 percent is not moving you in the proper direction.

So what we've said is, we think financial neutrality requires both steps: accurate risk adjustment and then going to 100 percent. Not paying more if in fact the plans are benefiting from risk selection. So that was the reason for --

DR. ROWE: I understand that and I appreciate that. And for all the reasons that Bob mentioned, even though we may be paying more than Medicare would be spending on those people, it's not enough to entice the plans to enter or to stay. So I think we understand that. I was under the impression that the difference between the characteristics of the M+C beneficiaries and the fee-for-

service beneficiaries had narrowed, or was narrowing. You would have the data and I don't, and we can hear about that.

But notwithstanding that, it would seem to me that some incremental approach to try to do something during these two years might, from a policy point of view, be warranted, if one accepts the fact that Congress and the American people appear to want to have this program. That's just where I come out, I guess. But I'd be interested in the data on the difference with respect to the characteristics of the M+C versus fee-for-service bene's at this point, whether it is in fact narrowing or not.

MS. NEWPORT: I think I would have the same issue that Jack does, although I came in in the middle of this conversation. I apologize for that.

The issue in terms of a risk adjustment, imposing it as adequate and imposing it as soon as possible at this point I think it just another level of uncertainty that's imposed on the program. So I think that from the overarching policy standpoint, a risk adjuster is something that's been very, very well imbedded in the thought process around what M+C should be.

But in effort to make Sheila feel maybe younger on

some of this stuff --

[Laughter.]

MS. NEWPORT: My recollection unfortunately is back to TEFRA on this, where the whole thought process was not about saving Medicare money. It was providing options, and indeed having health plans participate in Medicare in the same manner they participated in the commercial or under-65 markets, which was prepaid health care.

The value added that may have accrued to the program -- in this case the beneficiaries -- there was this what I'll call a safety net, for lack of a better word, which was a filing system that said that in case the revenue was more to the plans than the actual value of the benefits, the plans were required to add in other benefits. That value and the savings didn't accrue to the government. It accrued to the beneficiaries.

So the savings in terms of so-called overpayment is not necessarily savings -- and I think the frustration on the policy side has been it hasn't been savings to the government, but it has been savings to the beneficiary. As the argument of savings to the government has overwhelmed the initial thoughts and behind the program, then we get

into these rather awkward arguments about adjusting payment so that it's the most value at a different level than it was anticipated being from at the onset of the program.

So I do have problems right now in terms of trying to stabilize a program that had value for many years, and still has perceived value to the beneficiaries, with a precision on payment that seems to then, again, overwhelm the additive value of the drug benefits. Which really does help the beneficiaries in other ways too because they don't have to buy Med supp products to pay for the differential and deductibles and copays they would incur on the fee-for-service side.

So at any rate, I guess hopefully Jack and I are aligned here, but I think that as soon as possible, to me imposes an undue burden on plans. I think that I would comment that way. I am concerned about that, because we will go from hundreds of thousands of data submissions, even with a skinnier dataset that we anticipate on risk adjustment to still millions.

Our experience so far with the data submission on risk adjustment has been very problematical. If you just look at yesterday's notice on the USPCC update, we're having

adjustments to the base that seem to occur every year because for some reason HCFA -- the tail on the data, each year they've overestimated what they should pay us. It seems to me that the five-year lookback on some of this data, it's the same experience we had on the fee-for-service side using 1999 data to base our updates on for any of the other sectors.

So I'm very concerned with the wording of this, and that at this point, without knowing what Congress is even going to do this year or what reform will look like, if we even get to that, I find this counterintuitive to say, let's put this in place and then expect that it will stabilize the program.

MR. MULLER: It just strikes me at a macro view we've kind of ground ourselves to a policy halt here, because the plans don't want to offer the benefit because it's just not financially attractive to them anymore. The government doesn't want to, in a sense, keep sponsoring it because it feels it's overpaying. And the beneficiaries don't want it any more because without the added benefits that were available four or five years ago to attract them in, they're not willing to have the kinds of constraints on

choice, especially as the insurance market has changed quite a bit.

So I think in some ways that we unfortunately have fallen into a kind of black hole here -- not to create another metaphor -- but where everybody doesn't want to go forward for a variety of reasons. The way in which the program was financed five, seven years ago by fairly considerable changes in behavior; e.g., constraints on hospitalization, et cetera, are not as feasibly, medically, politically, legally any more. So the way in which essentially the program was financed is not there any more.

So I just think we're in a bad spot in terms of going forward because none of the parties to the transaction, the plans, the payer, or the beneficiaries, want it.

MR. SMITH: Ralph headed in the same direction I wanted to. The difficulty here is we do know that we could pay enough to stabilize the system; at least keep plans in and keep enrollees enrolled. But we have no idea whether that's a good idea or not. Jack is suggesting that we ought to go partway down that road because Congress might go partway down that road.

But it seems to me that we've laid out an argument here that does reflect the black hole that Ralph suggested. That if this plan is going to work, it's got to work in a financially neutral way. That has to be part of what we say is a minimal outcome. Going ahead with 100 percent before there's a risk adjuster in place violates that proposition.

Now it seems to me if we're going to do what Jack suggests we need to back away from what seems to me to be, both from a policy point of view and a principle point of view, a very important starting proposition. There was always some uncertainty about whether this would work. Now that uncertainty is intensified. The only thing we know is that there's some amount of money that we could throw into the system that could make it work. We don't want to do that. That would violate the notion of financial neutrality. So Jack wants to violate the notion of financial neutrality a little bit on the hope that we'll get a little bit of stabilization.

I don't think stabilization is our objective here, and we need to be -- or we certainly haven't said stabilization is our objective. If we're going to head down that road we need to revisit the principles that we've

articulated over the last couple years. I'd be very reluctant to do that.

MR. FEEZOR: I guess I would have to take a little exception with Ralph's observations. I have 250,000 retirees in my program; three-quarters of them, up until about two years ago, were in Medicare+Choice programs. I went from five Medicare+Choice vendors to two. I'm not sure how -- and I can tell you at each one of those withdrawals where Medicare supplemental arrangements were substituted for Medicare+Choice I and my board took a lot of heat. So I think at least for those who have been a part of it, who have enjoyed -- probably have enjoyed without paying the full value, I think. Ralph, that's where I think you would be right. If enrollees have to pay maybe full value, however you might calculate that, there's probably a little different mix. But those who have it clearly want it.

I guess the other thing is, I take some agreement with Jack. When I was with the Blues I remember we were still talking about risk selection in the FEHBP program in terms of the high option, low option and could we correct that. The issue of risk adjustment has been around. It's a question of which of 15 methodologies, now down to six, seem

to have better predictive powers. It really is, I think, a matter of lack of concentrated will to in fact go ahead and make a prudent choice, decide what risk adjusters you feel like make some sense. You're never going to get to 100 percent. You'll probably never get much above 50 percent in terms of predictive, at least in our lifetimes.

The question is, is it a fundamental tool that can help assist the program in terms of achieving the value for enrollees. I don't know where I come out on that except that I think it's probably time to call the issue. If in fact we believe in financial neutrality and in fact that risk adjustment is in fact a step in the right direction, then I think there needs to be some urgency and intensity brought to that. And dealing with data submissions, in all due respect, none of my vendors -- some of the same individuals -- appreciate the kind of data that I try to get from them to validate the rates that I have to deal with and negotiate. That's always going to be a complaint and it should not stand in the way of in fact designing a system for long term permanence and value.

DR. STOWERS: I don't want to interrupt the flow of this conversation. I just had a question on

recommendation two. I know we've talked about the carve-out in other places and yet we say here 100 percent. Are we talking column two or column three as the end recommendation two?

DR. HARRISON: We don't in that recommendation say how we would measure local fee-for-service spending. My presumption is that we're doing column three.

DR. STOWERS: So should we put, less the carve-out on that?

DR. HARRISON: We could if you want to.

DR. REISCHAUER: I'd like to side with Jack and disagree with David. I know that makes you very uncomfortable, Jack, but stick with me.

[Laughter.]

DR. REISCHAUER: There is a very real possibility that Medicare+Choice -- not talking about private fee-for-service plans but plans, you guys -- is on the endangered species list and by the time we get risk adjustment and financial neutrality it's going to be extinct. We have to ask ourselves, is preservation of this type of entity worth something because we think it might play some role in future Medicare policy? If it becomes extinct it's not going to

come back. Or it will come back only over a very, very long period of time.

I think what Jack is saying is, why don't we go to 100 percent fee-for-service now. I think you can make a case that that is not necessarily bad policy, even without risk adjustment, because of our ignorance at this point. There's been huge changes in the enrollment in these plans. Some plans have gone out of existence. We have a different set of incentives by the lock-ins that we have in place, and that will selectively cause disenrollment or different people to enroll. Many plans now are charging premiums for the benefits that they're providing, whereas they didn't before. So this would probably drive the healthiest of people out of these plans. And then there's always the claim that the group is aging.

So I don't really know I don't think, and I don't think anybody knows the extent to which we have favorable risk selection in these plans right now. It's conceivable that there isn't much of that now. We gather our data and five years from now we say, you know, it's funny, they went extinct and there wasn't this.

Now the thing that worries me about going to 100

percent within the risk adjustment in place is that we might never get the risk adjustment. The political forces that we've seen operating over the last few years might be so powerful that that's the end of it in terms of trying to make the adjustment. But I think you can make a pretty good case that moving to 100 percent now with risk adjustment phasing in over the next three or four years is the prudent course, if you think having plans that could be part of a competitive model or could give people choice is an important thing for keeping our options for the future of Medicare as broad as possible.

MR. HACKBARTH: I don't want to see the program go out of existence. Both in my government service and in my private career, it's basically been involved in trying to create managed care delivery systems that can serve both private and public enrollees. So I'm a believer in this.

The biggest reservation, Bob, I have about let's do something temporary to keep it alive is that I think that, yes, there are problems on the public policy side: problems in our risk adjustment, problems with the ceilings and floors that I think are destructive and making life more difficult. But I think part of the difficulty we face right

now is attributable to what's happening in the plans themselves and how managed care has evolved, for very understandable reasons. But it's evolved in a way that it's less able to manage care.

The networks are very large, if not all-inclusive in some cases. For a variety of reasons, including political and public relations, tools that could help manage costs have been abandoned. So the difference between what the private plans are offering and what fee-for-service Medicare is offering has diminished. I think that is at least as important in the fiscal difficulties of the plans as anything on the Medicare side of the ledger.

So what gives me pause is paying more money, more than they we would have spent in Medicare, for something that's basically become Medicare-like. I don't see the public interest in --

DR. REISCHAUER: But what I'm saying is, I don't know if we're paying more than we would pay under Medicare. I think we have a lot of studies based on data from three to 10 years ago, but the world has changed tremendously since then. I'd like to actually hear from the staff on whether that's true. Maybe I'm wrong. Maybe there's some new

studies out that -- I mean, you guys had a regression and I didn't know where it came from, 1.016. So maybe that's the latest.

DR. HARRISON: That was without risk adjustment. But we do have risk adjustment now. Right now it's stuck at 10 percent on the PIP DCG. If the only thing you did was to allow that to go higher I'm sure that that would -- it might even -- well, I don't know if it would over-compensate or under-compensate but it would certainly do some risk adjustment that could be considered adequate.

DR. ROWE: But what about the populations now as far as the most recent data that we have, how much difference is there?

DR. ZABINSKI: That data I think is -- I'm trying to remember -- it was fairly aged as well.

MR. HACKBARTH: Joe, can you shed some light on this?

DR. NEWHOUSE: I haven't seen any real recent data. The most recent data I've seen was the distribution HCFA put out when it announced the impact of the PIP DCGs by plan, which you'll recall was where we got the 7 percent hit when fully phased in, but there was still a spread with

several plans gaining from risk adjustment.

The point I wanted to make, I come out generally where Bob Reischauer does, but there's an issue about how much we want to be governed by the average or the mean versus the distribution. There was quite a spread in the impact of risk adjustment, and the flip side of that being how much selection as measured by PIP DCGs, across the different plans. Some plans were gaining a lot. As I recall there were some plans that would lose in the teens percents of their reimbursement, while other plans would have gained. Another way of saying that is, some plans are profiting a lot, other plans are actually suffering from adverse selection.

So I'm not sure it's all that persuasive to say that on average, across all plans, there's selection that goes against the government and therefore we shouldn't go to 100 percent. Nor as we look at the impacts in this table by geographic place, it's not clear that those are actually the real impacts, because we don't know what the selection is in each of those places. This is before any selection occurs. And then even within those places, insofar as there's multiple plans, there will be different impacts by plan.

So I think the way we want to think about the going to 100 percent point is some of the plans right kind of in the middle of that distribution would move up to where they would benefit. Other plans are still going to be losers and winners in this. But it's going to be a quite different picture across all the plans. I'm just impressed with how much of a spread there was across the plans.

While I've got the floor I wanted to say one other thing that doesn't bear immediately on the policy but it does bear on the chapter, which is the chapter -- it didn't come into this discussion, has a proposal or some language about if we go to competitive bidding the government subsidy should be at the lowest bid.

I don't think we should take a position on that issue. I think that's the first rank political question and goes to the division of the burden between beneficiaries and taxpayers. We can have a financially neutral system with the government paying anything so long as the beneficiary is able to collect all or almost all of the difference if the beneficiary chooses a plan that costs less than what the government is paying. I think that's the principle we want to insist on.

DR. HARRISON: We did not intend to say that you would pick the lowest. That was just the easiest example to explain.

DR. NEWHOUSE: That's not how I read the language in the chapter.

MR. HACKBARTH: I agree with what you're saying, it's not written as an endorsement, but an illustration of how it might work. There are other potential models that maybe we would do well to make reference --

DR. NEWHOUSE: We should strive to be explicitly neutral on, or agnostic, about what the government contribution should be, or the level it should be set at. The principle we want to emphasize is that the beneficiary pays or receives the difference in either direction.

MR. HACKBARTH: The benefits in terms of reducing program costs of the model in the paper are greatest, but also it has the greatest risk in terms of selection problems and the like. So again, choice is trade-offs to be made among different public policy goals there and I think we could add to the text some discussion that highlights that.

DR. HARRISON: The only other thing was that I tried to say that if you were to go to some other model the

effects would be similar. They may just be different in degree, but they would be similar in kind. That was the other thing that --

DR. NEWHOUSE: I don't even see any reason they would be different in degree. The first order effect is who pays, the beneficiary or the taxpayer?

MR. HACKBARTH: Right. But one of my concerns about the lowest bid model with the Medicare entitlement being redefined, you're entitled to this benefit package from the lowest bidder, is that then the beneficiary becomes the risk bearer in terms of selection issues. If the cost of Medicare is driven up by adverse selection, the beneficiaries remaining in the traditional program have to pay for it in increased premiums, as opposed to some other models where the government would continue to be the bearer of the risk of adverse selection. That's a critical policy choice I think.

DR. NEWHOUSE: Yes, but it's not clear that Congress needs us to tell them how to make that choice.

MR. HACKBARTH: We ought to be elucidating the choice as opposed to --

DR. ROWE: We've had a lot of discussion of this

other issue. I wanted to move to one other issue for the chapter also and put my geriatrician hat on for a minute. I think that it would be helpful to look at this situation not only from the point of view of the government, the program, which has been the lens that we've been discussing about neutrality, et cetera, and whether the government is overpaying or underpaying, or isn't overpaying as much as it might have been, et cetera, but from the point of view of the beneficiary.

A lot of the implicit comparison in the chapter is the traditional fee-for-service program versus Medicare+Choice when we talk about the beneficiary in that one section. I think the relevant comparison is traditional fee-for-service plus Medigap versus Medicare+Choice.

The overwhelming majority of the beneficiaries in the traditional fee-for-service program have a Medigap supplemental program. The premiums are changing there. That situation is fluid. For my mother who's 92 in New Jersey trying to figure out what to do, it's what it's costing her out-of-pocket vis-a-vis choice and these other restrictions for the Medigap policy plus Medicare versus what she can get from Medicare+Choice, and what's happening

to the supplemental premiums that Medicare+Choice is charging. You mentioned that, but there are some limitations on what can be charged, et cetera.

I think it would be helpful to add that dimension to the chapter because that's really where the beneficiary is. As Allen pointed out, his beneficiaries migrated from Medicare+Choice to Medicare plus Medigap, and weren't happy with it, and they're probably unhappier now but there's nowhere to go. So that would be something I'd ask you to consider adding some stuff in.

MR. HACKBARTH: I have Alan, Janet, and David, then we need to, I think, start to bring this to a conclusion.

DR. NELSON: I favor the notion of Medicare beneficiaries having choices. As a beneficiary, I'm perfectly willing to go to the Congress and lobby for some policies that would allow that to happen. But I think it's important for the Commission to have some principles and adhere to those principles, and they've been articulated in the past meetings, in favor of moving to the financially neutral payment system and an adequate risk adjustment system. I think it would be a mistake for the Commission to

retreat from those under the notion that some fix is necessary in the shorter term.

There will be plenty of other people that can advocate that, so I support what Dave said earlier.

I also support the recommendations. Getting back to the recommendations, I support them.

MS. NEWPORT: I guess maybe that's my question rather than a comment is -- I don't have a good sense of where we are with this right now, but I appreciate the comments of Bob and Alan as well.

It's not that just -- we recognize that supplying data is a necessary part of being in business. I think the issue right now is at what cost and the timing in terms of the stability of the program. I was rather gratified this past year or so that folks came around to the budget neutrality of paying 100 percent with a proper price fixer, if you will, stabilizer in terms of -- is the money going to the right place and is it of value to beneficiaries ultimately?

So I wanted to be clear that my concern -- what i want to be clear on is the timing of this and the level of uncertainty, so that folks know that that's the issue is,

when you're making long term business decisions and every year you have a bit of a surprise in terms of what's going on, what you're going to be paid, what your revenue is going to be. And then you have to impose that surprise on your customers, your beneficiaries. And then you have to deal with the money markets as well in terms of what you're doing. It is a very, very disconcerting period of time.

Notwithstanding the fact that everybody seems to think that lack of choice to beneficiaries once they're in a plan, beneficiaries love the program. We have extraordinarily good response to being in plans as a matter of fact. That's why it grew so rapidly; the benefits were good. I think that that value added was an important notion that we don't want to lose.

So I'm not sure where we've been left with the wording of the recommendation, but I want it understood that being in a Medicare+Choice plan didn't even occur to some beneficiaries as being a restriction on their choice. It actually -- they were very happy with it. I think that's what we'd like to go kind of what I call back to the future a little bit is, let's get to some stable, predictable pricing mechanism instead of having every six months or so

something that doesn't allow you to figure out what your benefits -- if you can afford the benefits you're offering 18 months ahead of that time, what risk adjustment will really do, at whatever level that is.

Then you're looking forward to perhaps something like a competitive bidding system. This makes it very difficult to make decisions around what you're offering, what your revenue is going to be, and even then -- of course the ultimate customer is the beneficiary, about what they're going to have in place from one year to the next.

So I'm trying to bridge a little bit of a gap here to say that paying in a financially neutral way is a big step forward. I think just recognizing risk adjustment in and of itself needs to be done carefully and imposed carefully, otherwise as policymakers here we shouldn't be surprised that there's further destabilization if it's not done in a thoughtful and careful way.

I'm looking at more of a minimalist approach right now. We have done the data for the inpatient hospitalization. It's 10 percent. The outpatient and the burden that it was going to impose on fragile provider networks, thus de facto exiting the markets, was also very,

very concerning to us in terms of what we were able to be able to commit to to our provider partners in the system.

So again, I started out with where are we with this recommendation, but I appreciate the comments of those that recognize that a bit of caution here is worth the -- able to bridge to whatever we go to next.

DR. NELSON: Glenn, can I clarify, because I think Janet may have misunderstood me, and if she did others may have too. When I was saying that choice was important to beneficiaries, I meant the choice between traditional Medicare and Medicare+Choice and its various plans. I just want to make that clear.

MR. HACKBARTH: David, then Bea, and then we really need to turn to the draft recommendations.

MR. SMITH: I'll try to be very brief. First, I share the concerns that Glenn and Joe raised about the language on lowest bid and maybe we can help work on that.

Let me return to Bob's endangered species analogy. If our task her is to make sure that the circumstance is in some way mitigated then there's no particular reason to stop at 100. We ought to be asking ourselves, how much money do we need to throw into the system in order to prevent further

extinction? That's the logical consequence of Bob's proposition, which is that we want to hold on to this apparatus because as the system evolves and as we learn more we don't want to be bereft of these institutions.

I don't think that's what we intend. But if we do, then I think we need to open up the conversation to what's the right number? Is it 105? Is it 110? Is it 100? If the objective here is back to what we've said before, which is appropriate financial neutrality, then it doesn't seem to me we can argue to go to 100 absent appropriate risk adjustment.

But if our objective is holding onto this species which is in difficult shape then there's no particular reason to think 100 is the right answer. I don't know what the right answer is, Bob, but --

DR. REISCHAUER: No, if they can't make it at 100, let them go the way of the dinosaur.

MR. SMITH: Why? You began with, we may have an interest in holding onto this beast because it may be valuable to us later.

DR. REISCHAUER: And we don't know right now what an appropriate risk adjuster would do, because there's been

so much turbulence in these plans, in these markets, in the conditions that face participants, in the sense of premiums and lock-ins. The data suggested to us in the past that we were overpaying plans by 5 or 7 percent may be invalid.

MR. SMITH: I don't disagree with that, Bob. But where you started was not with what we don't know and the appropriateness of modesty. I agree with that. But where you started was, we have an interest in the preservation of the species. If we do, then our recommendation ought to reflect that rather than saying, let's go to 100 absent the kind of risk adjustment which we think is necessary to make 100 work.

DR. REISCHAUER: We have an interest in preservation only to the extent that we think this species might be able to compete on a level playing field, and let's make sure that we don't tilt the playing field against it. That's all. And it would be just a two-year, three-year, whatever it is, adjustment. If we're paying plans now 98 percent, we aren't really talking huge change.

MR. SMITH: I suspect that if we'd find that if we went to 100 and it didn't work, your argument would turn into, let's try 103. It doesn't seem to me that's the path

we ought to set off on.

DR. BRAUN: I'd like to preface it by saying I agree with the preface that Alan gave about choice for beneficiaries and so forth. And I agree with Janet that those who are lucky enough to have that choice and have chosen managed care really are delighted with it, and there's a lot of upset when plans exit.

However, with the financial neutrality I'm concerned, as Bob mentioned, that if we do that now it may take some of the steam out of the risk adjustment. Plus the fact that I'm concerned that if indeed the plans do have a healthier population -- and some of the older plans actually may not any more because the people have gotten older and it's costing them much more. But if indeed that is found out and we have already moved to financial neutrality, are they going to be able to back up? What's going to happen indeed, because that might mean that some of them would not be paid as much as they had been before. So that's a concern.

MR. HACKBARTH: What I'd like to do at this point is turn to the draft recommendations. Here's where I think we stand. In terms of the two draft recommendations that

the staff offered I think we agreed at the outset that we really don't need number one. That it's superfluous. It's really taken care of by the initial clause in recommendation two.

Bob I think has a proposed alternative to draft recommendation two which I'd like him to go ahead and explain.

DR. REISCHAUER: This is option two for this draft recommendation. It would say, the Congress should set payments to Medicare+Choice plans at 100 percent of per capita local fee-for-service spending, and an adequate risk adjustment mechanism should be implemented as soon as possible, or feasible. So this separates the two, because obviously you could go to 100 percent right now.

Now I would assume that what the text around this would talk about was our ignorance with respect to the underlying risk of participants in these plans at present, the desire for a level playing field risk adjusted in the long run, and concern about the withdrawals that have taken place, and the possibility that between now and 2004 this industry may be so weakened that it is no longer viable when the playing field does become level. This is just an

alternative.

DR. ROSS: Bob, what does your alternative proposal imply about the use of PIP DCGs as the existing risk adjuster? Allow that to affect payments fully?

DR. REISCHAUER: That's above my pay grade.

DR. ROSS: That's the first question we'll get asked.

DR. REISCHAUER: I'd go to Joe to see whether we should -- you mean phase it in completely as opposed to leave it at --

MR. HACKBARTH: Where are we in the phase-in right now?

DR. REISCHAUER: Ten percent.

DR. NEWHOUSE: The implication seems to be just that we should accelerate the phase-in. That's how I would have read this. When we say an adequate program, I mean I don't -- we talked long ago about what adequate meant. But as Murray says, what's on the table is the PIP DCGs or all sites. We're just basically saying full steam ahead as I would have read this.

DR. STOWERS: I just have a question of Bob. Do you mean at least 100 percent, or those that over 100

percent will decrease down to 100 percent? Will Portland go from 553 to 440?

DR. REISCHAUER: We would go to 100 percent and then do as much risk adjustment as feasible at this point.

MR. HACKBARTH: The answer is, Portland is there because of the floor, and our financial neutrality proposal involves elimination of the floors.

DR. REISCHAUER: Get rid of the floors, right.

DR. STOWERS: So they would go down.

MR. HACKBARTH: They would go down, yes.

DR. STOWERS: So is there a lack of stabilization because of those that are over, which some are on here, are going down, when they have established plans that are in place? We're talking destabilization.

MR. HACKBARTH: Again, we're reopening principles that we agreed to many months ago now, and a clear implication of financial neutrality is that you eliminate the floors.

DR. ROSS: The other question that remains on the table is when we talk about local fee-for-service spending is that defined to include or exclude payments for medical education; the carve-out?

MR. HACKBARTH: So what I would like to do in terms of process is we have the staff's draft recommendation two. Bob has offered an alternative to it. I'd like to vote on Bob's alternative and then if that doesn't carry then turn to the staff recommendation. Any objection to that process?

MR. MULLER: Bob's alternative in a sense takes the when out, right?

MR. HACKBARTH: Yes, he's saying do it immediately --

MR. FEEZOR: That's without --

MR. HACKBARTH: -- because of the uncertainty.

MS. NEWPORT: I guess I'm not settled on our understanding of what we think Bob's amendment means for risk adjustment. Is it full 100 percent data submission right now, or is it this more compromise proposal that CMS is going forward with?

DR. REISCHAUER: Presumably we have some risk adjustment information that we have chosen not to implement fully, and at the same time CMS is refining that, which I would encourage and think is the right thing to do. Eventually that would supplement what we already have.

MS. NEWPORT: So I just want to make sure our understanding is clear about what that means.

MR. HACKBARTH: Janet, let me see if I understand this correctly. There are two separate issues. One is the phase-in of PIP DCGs. The second is expansion to include non-hospital utilization. What I hear Bob saying is that we ought to move as quickly as possible to do the PIP DCG piece. In terms of the expansion to other sites, the analysis and weighing that is going on in CMS is appropriate but it ought to get done as soon as possible.

DR. REISCHAUER: I changed now, at Lu's suggestion, the word implemented to phased in. And as soon as possible sort of makes it sound like, go to 100 percent next year. We really need some kind of word that suggests at a pace that doesn't disrupt -- I'm trying to save this entity. I then don't want to kill it by having it eat too much medicine in a short period of time.

DR. HARRISON: There is a current phase-in program that's in law, although the thought was that the PIP DCG would be replaced by the multi-site at that point. But do we want to go with a phase-in schedule and leave it up to CMS whether they're going to do PIP DCG or multi-site as

it's phased in?

MS. NEWPORT: I think the statute makes the methodology CMS's choice. If we're going to stay with the status quo on this I want it clear, and maybe Bob can reread his --

DR. NEWHOUSE: I think the principal way would be, if anything, to accelerate over where CMS is. But I agree, we don't want to destroy the program to save it.

MS. RAPHAEL: Could you read your recommendation now as it's revised?

DR. REISCHAUER: I don't have the right last word because we need some language about --

MR. HACKBARTH: That could be handled in the text though. There isn't a single right word to capture the idea.

DR. REISCHAUER: Congress should set payments to Medicare+Choice plans at 100 percent of per capita local fee-for-service spending and an adequate risk adjustment mechanism should be phased in as soon as feasible or possible.

MS. BURKE: I wonder if I could just ask a practical question in terms of the time frame and the impact

of this. Is it my understanding the minimums go away? So going to Ray's point -- I'm trying to understand the implications of all that. So to Ray's point, there will be plans that drop. And your expectation, given what you did previously and what you doing today, as to when that will actually occur?

DR. REISCHAUER: I think if we're practical about this, what will happen in the legislative environment is they will freeze the floors and let the sea rise up past them, and it will take 20 years in Lincoln County, Nebraska to get there but...

MS. BURKE: Right. I'm just trying to think of the next actual consideration of this will be in the context of what happens to these plans, and the potential disruption in the short term, particularly for the plans who are at floor who are in these rural areas. I can think of a variety of states for whom that will be an issue, Iowa being among them.

DR. REISCHAUER: But I think the text should say, whenever we refer to moving to a level playing field that this should be done in a way that doesn't cause undue disruption. An awful lot of these places we're talking

about imposing a hardship on nobody because there are no plans. So it's sort of like, let's not worry too much about this.

MS. BURKE: Right. I'm just trying to think of the practical realities of how quickly this moves forward.

MR. HACKBARTH: Okay, any further clarifications necessary on Bob's --

MR. MULLER: The basic argument for this is a kind of endangered species argument. Basically, this is something worth keeping until --

DR. REISCHAUER: And our ignorance about --

DR. ROWE: The populations may not be that different so we may not be overpaying.

DR. REISCHAUER: And if we turn down this we go to the old recommendation. So that's the option.

MR. SMITH: But Bob's correct observation that we're very unlikely to lower anybody at the current floor would allow us to rewrite this recommendation to say, if you're above 100 percent, you stay there. If you're not at 100 percent, you go there, and maybe there will be risk adjustment sometime in the future. That's, as a practical matter, what we vote for if we vote for Bob's modification.

DR. HARRISON: Instead of doing the phase-in as quickly as possible, you could just leave the current phase-in schedule so that you know something will happen.

DR. NEWHOUSE: We could say something like, at a minimum, the current phase-in schedule should be maintained, or if possible, accelerated.

MR. HACKBARTH: Just say that in the text.

DR. REISCHAUER: Phased in at least as rapidly as is called for under current law.

DR. ROSS: The other issue for clarity to add in the text is your assumption about the definition of local fee-for-service spending on the med-ed payments, and whether in text you want us to describe this as embodying, to put it bluntly, column two versus column three in the table that you've seen.

MS. RAPHAEL: Aren't we discussing that next?

MR. HACKBARTH: There is not a specific draft recommendation on the carve-out issue. We discussed at our last meeting a recommendation to say that there should not -- that it should be the total fee-for-service cost, including medical education and that didn't pass. I can't remember the vote but --

MS. NEWPORT: But if you're going to full fee-for-service -- I was separating the issues differently last time in terms of what the base should be. So aren't we confusing the issue, which was reallocation of some of the GME in a way that wasn't beneficial to areas that didn't have a lot of GME?

MR. HACKBARTH: I don't think so. I think we had a quite explicit discussion of whether this is the full fee-for-service cost or fee-for-service minus medical education. We discussed it at length. It was a split vote but there was a clear majority in favor of excluding the medical education payments from the private plans. I think it was unambiguous. Whether it's the right call or not is another question, but I don't think there was any ambiguity.

DR. HARRISON: So did you want that in recommendation language or in text?

MR. HACKBARTH: Text. Are we ready to vote on Bob's proposed amendment? Everybody has got it in their head?

MR. FEEZOR: That is with text on the accelerated -- no less than --

DR. REISCHAUER: At least as rapidly is in the

recommendation.

MR. HACKBARTH: Read it one more time.

DR. REISCHAUER: The Congress should set payments to Medicare+Choice plans at 100 percent of per capita local fee-for-service spending, and an adequate risk adjustment mechanism should be phased in at least as rapidly as called for under current law.

MR. HACKBARTH: All opposed?

All in favor?

Abstain?

It passes. Did you get the count on that? What was the number?

MS. ZAWISTOWICH: Alan Nelson and David Smith voted no, and Mary abstained.

MR. HACKBARTH: Okay, I think we're done then on Medicare+Choice.

DR. ROWE: I think it's interesting to note that we had two votes with respect to these issues. One of the issues could be interpreted as having passed to give the plans less money, and two people voted against it. The other passed having interpreted to give the plans more money with two people voting against it. So it looks like at some

level the system might be working here.

[Laughter.]

MR. HACKBARTH: The next item on the agenda is adjusting for local differences in resident training costs.

MR. LISK: This probably can be pretty quick. At the last meeting we discussed some analysis that we looked at for adjusting local differences in residency training costs, which part of a report that's required by, or a study that's required by Congress. We have in your briefing materials a draft letter to send to the Congress on the conclusions that the Commission reached at the last meeting. So the purpose today is for you to approve this letter, or if there's any modifications you might to make, to make those modifications.

So briefly, to review what the congressional mandate was, Congress in committee report language in the Balanced Budget Refinement Act of 1999 asked, is the physician GAF an appropriate factor to adjust GME payments for geographic differences in the cost of physician training? They wanted the Commission to make recommendations by March 2002 on a more sophisticated or refined index to adjust direct GME payment amounts, if

appropriate. Again I want to say, they wanted the Commission to make a recommendation if appropriate.

Just to briefly review in terms of Medicare's GME payments. GME payments are based on hospital-specific payment rates updated for inflation. The BBRA established a floor and rate of increase ceiling to these amounts so hospitals with low present amounts would get their payments raised. This floor and ceiling is a geographically adjusted national average amount, and the geographic adjustment is the physician geographic adjustment factor used in adjusting physician payment rates.

BIPA raised the floor payment rate to 85 percent of this geographically adjusted national average. So hospitals in between the floor and rate of increase ceiling still get their current hospital-specific per-resident amount. So most hospitals do not receive the same payments as they would without this legislation. The ceiling is a rate of increase ceiling so it just affects -- those hospitals are frozen for two years and have reduced updates in subsequent years.

So in last month's analysis we examined the following geographic adjustment factors and looked at them:

the physician GAF, the one that's currently used; the hospital wage index; a resident teaching physician wage index developed from data from the current wage index survey; an index based on per-resident costs or payments; and potentially a composite index of one of these -- two or more of one of the above indices.

In looking at our analysis in terms of -- the next slide summarizes the basic findings from the Commission and what's included in the letter are that we found that resident stipends don't vary tremendously across the country. As you recall, basically the 10th percentile and the 90th percentile only have about a 9 percent difference from what the average is, up or down. New York City is probably the most expensive at about 16 percent or 17 percent above the national average. That's not a lot of variation when you compare it to what the variation is in the hospital wage index and stuff like that.

The physician GAF though, of all the indices we looked at, is much less variable than other indices. That index is much more of a pure price index in terms of its construction compared to the others.

Using a different index would also change payments

for many hospitals without necessarily improving payments. So in terms of one of the factors that we were considering was whether, if we found something different, is it worth the cost of changing, and I think that's one of the conclusions we came to.

Current available data on resident teaching physician costs which might be more reflective of what we're seeing in per-resident payments, the quality of that data is not reliable enough really to develop an effective alternative. And the cost of developing a reliable index based on that data probably outweighs the cost of the potential benefits of such an index for use as it's currently being used.

We do have a paragraph at the end of the letter though that does state that if Congress did move to a national average they might want to reconsider that and have data developed more specifically on resident salaries and teaching physician salaries. It's different from the wage index. Because part of the problem we found with the wage index was that it is hourly wages for residents and what does that really mean when you have residents who are working 80 hours, 60 hours and stuff. But we know the basic

salaries don't vary substantially there.

So basically come to the conclusion for the letter is that the physician GAF provides a reasonable method for adjusting floor and rate of increase ceilings for geographic difference in the cost of residency training. So we'd like you to approve the letter, or if there's any modifications, please let us know.

MR. HACKBARTH: Any questions about the letter? I think we actually held a formal vote at the last meeting, didn't we?

MR. LISK: No. That's why --

MR. HACKBARTH: So all in support of the letter, I guess?

DR. ROSS: Comfortable with the conclusion.

MR. HACKBARTH: All opposed to the letter, raise your hand.

All in favor?

Abstain?

Thank you. We were asked by the Congress for our opinion on this and we need to vote on the record and say, this was our opinion.

We're going to take up some unfinished business

from yesterday having to do with the pass-through for new technology and the outpatient payment system. We also have to reach closure on the skilled nursing facility issue. So we'll do outpatient services first.

Chantal, whenever you're ready.

DR. ZABINSKI: Yesterday we talked about a single draft recommendation, but what Chantal and I ultimately decided was to break this into two recommendations because we thought including all the points that we discussed yesterday made a single recommendation a little bit unwieldy. But the two recommendations you have are on a single handout so you can see them at the same time. They fit very much together.

The first recommendation says, the Congress should replace the hospital-specific payments for pass-through devices with national rates to be set by the Secretary. Also, the Congress should give the Secretary authority to consider alternatives to average wholesale price when determining payments for pass-through drugs and biologicals.

The next recommendation says, the Secretary should ensure additional payments are made only for new technologies that are expensive in relation to the

applicable APC payment rate. Also, the Secretary should avoid basing national rates only on cost as reported by manufacturers. Finally, the Secretary should ensure that new technology payments for inpatient and outpatient services are based on the same principles.

DR. STOWERS: I have a little bit of a concern about the second one on the second recommendation, avoid basing national rates only on cost as reported by manufacturers. I think that might be something to talk about in the text but it sounds -- it kind of infers that their pricing may not be appropriate or something like that.

DR. NEWHOUSE: No, it just says -- what we want to say is, don't use cost reimbursement. And I'm actually not sure why we're saying only. Just, avoid basing rates on cost.

DR. STOWERS: I think it could be interpreted a lot different than that is what I'm saying. That point I don't think is coming across clearly as to what our discussion was.

MR. HACKBARTH: Other comments?

DR. BRAUN: Not on that, but I wondered whether expensive standing by itself is enough, or whether we should

have significantly expensive or something of that sort in that first...

DR. NEWHOUSE: Glenn, should we say, as reported by manufacturers or hospitals since we were talking about acquisition cost also?

MR. HACKBARTH: Yes, I think actually it was more the hospitals we were talking about as opposed to the manufacturers.

MR. DEBUSK: Should that not be, ensure additional payments are made only for new technologies and substantially improved technologies? Isn't that what we had in some prior language?

MR. HACKBARTH: Right, we did. Let me just step back from this for a second. As I thought about the discussion yesterday one of the concerns I had was that we were repeating things that were basically happening already. As I understand the current situation, the criteria for the pass-through are being tightened, using both cost and clinical standards. Now they may be imperfect criteria, but that's already going on. That was one of the things that we wanted to see happen and it was happening.

The second big issue we had was, when something

does qualify for the pass-through, how do you pay for it? There was strong opinion that we needed to avoid a mechanism that was essentially a cost reimbursement. Try as we might, however, we've been unable to come up with a specific alternative at this point.

I would like to avoid being gratuitous in our bold-face recommendations. So one thought I had after yesterday's discussion was that in the text we could reinforce everything that's already happening and say, rah, rah, rah, this is going in the right direction. Then in the bold face simply say that the big, outstanding problem we see is how do we set rates for the pass-through items and we strongly recommend that it be done in a way that is not cost reimbursement.

Then if as a Commission we wish to pursue the issue further and try to come up with a specific mechanism we can do that for the future. So try to pare this down to what's really new and different. Does that make sense to people? Do people feel comfortable --

DR. NEWHOUSE: Is there any danger that the course that we're on would change? What you're saying is, we're on the course so we don't need to endorse the course. But that

would be true if we're firmly locked into the course.

MR. HACKBARTH: In the text again I would say, we think this is the right direction to be going. We support tightening up the criteria, both using clinical and cost. The one thing that is outstanding that really concerns us though is how you pay for the items that do qualify, and that's a bold-face recommendation.

DR. NEWHOUSE: I take that point. But on the first point the question is, is there going to be any effort to prevent or slow down the tightening?

MR. MULLER: I share Joe's concern because that's what happened last time. There was a smaller list and it got a lot bigger. That's what, at least my understanding is part of the reason we went from the 2.5 to 13, or let's say we exceeded the 2.5.

MR. DEBUSK: I think that's exactly right.

MR. MULLER: That's why I think the language that's in the bullet point, the first bullet point of point two is an important bullet point that reflects yesterday's discussion.

MR. HACKBARTH: If there are even a few commissioners that feel strongly about it then I think we

ought to go with the bold-face language for the whole thing.

Okay, so we've had two amendments offered; Bea suggesting that we ought to have some modifier of expensive to highlight that we're talking about really expensive, which can be done in the text. My preference as opposed to adding lots of adverbs to pound the table in the recommendation is just in the text to emphasize that we think that needs to be a tight standard. Is that okay with you, Bea?

DR. BRAUN: Yes.

MR. HACKBARTH: Then the other issue that I've heard so far was in the next bullet, and the proposal was to add hospitals.

DR. NEWHOUSE: I'm just wondering if we could strike only, we could strike as reported by manufacturers. So it would say, avoid basing national rates on cost.

MR. HACKBARTH: I always prefer simpler over more wordy. Does that sound right to people?

MR. DEBUSK: Cost only perhaps.

DR. NEWHOUSE: I wouldn't use cost at all. I would just say, avoid basing national rates on cost. I'm not sure what only buys us.

MS. BURKE: I think, Joe, the question is what is CMS capable of doing? If we explicitly prohibit them using cost as a base, do they have the capacity at this time to have another method?

DR. NEWHOUSE: They don't use cost, for example, for erythropoietin.

MS. BURKE: Right. But in the case of, as was noted yesterday, one of the issues and the problems here is that we don't have any history on at least the new technologies. So there is little in the way of -- I mean, EPO has been out there for a while so we're playing in --

DR. NEWHOUSE: Yes, but at one time it was new.

MS. BURKE: At one time it was new. But if we explicitly prohibit cost you go to -- I guess the question is, what does CMS go to?

DR. ROWE: Whose cost is this, Sheila? Is this the cost to the manufacturer, the hospital?

MS. BURKE: In Joe's system it's the manufacturer's cost --

DR. NEWHOUSE: I want to get rid of cost, so I don't care whose cost it is.

MS. BURKE: That's what I'm saying. He doesn't

care whether it's the manufacturer's or the hospital's. Joe wants to do away with cost. My question is, what's the alternative if we prohibit these costs?

MR. HACKBARTH: That's the crux of the problem here. By definition we're talking about things that are new and for which we have little information. At least part of the motivation for the pass-through, as I understand it, was because we didn't have the information to fold them immediately into the APC rates we were going to have to pay for them on another basis while we collected the data. Now we're saying, we don't like that system, for very good reasons, and there needs to be an alternative but we don't know what it is. We only know what we don't want, which is a cost-based system.

That's a bit of a dilemma there. If we knew the right answer we could even, setting aside administrative issues, skip the interim step of a pass-through and just put it into the APC rates. If we knew the right answer right from the outset. But we don't know the right answer.

MR. MULLER: And if you could anticipate the technology. It's not just a price issue. It's also a --

MR. HACKBARTH: I'm saying, once it's here, if we

know what the right rate is to pay for it we don't need to have a pass-through, we can just fold it into the rates, once it's here and --

MR. MULLER: If you could change the APCs every day of the year. And that's why you have a pass-through, because you can't change them every day of the year.

MR. HACKBARTH: That is the administrative reason. There is a process required to actually update these things so the pass-through is an administrative mechanism as well. But we're not going to resolve today how to set the rates. I think all we can say at this point is they should not be based on cost. And if we think this is a really important issue we can have staff work on it for the future and try to help CMS come up with an alternative approach. So I think that's where we stand.

If there aren't any other amendments --

DR. NEWHOUSE: I guess I'd observe that we've put in place all the post-acute prospective payment systems to get away from cost reimbursement in post-acute. Not that I want to hold that up as a shining example of what might happen here, but we certainly have put systems into place that we didn't know what was going to be in place when we

got downstream. We just said, do this. I mean, there was an interim system, obviously.

MS. BURKE: I'm sorry, Glenn. I don't mean to belabor this because I don't disagree with Joe's fundamental point, which is to move away from an inflationary system. Even in those cases, as flawed as they are, there was some history in the context of services we provided and the cost of those services. In this case we are in fact trying to anticipate what some thing or a process will cost going forward so that we can incorporate it into a payment system.

While we want to get away from a model that essentially has the incentive to have it be the most expensive; i.e., put it into the base. In the absence of a reference to cost I'm perfectly willing to let it be left to everyone's guess, but frankly, I don't know what the guess is. Is it the return on equity as you talked about equity? That raises a whole series of other issues. I don't think we can go there.

DR. NEWHOUSE: Not today.

MS. BURKE: Not today. So I'm happy to leave it vague, don't do it on cost. But my only question will be the natural one and the staff then will have to sort out is,

okay, what else? What is there?

MR. HACKBARTH: Sheila, would you prefer, based only on cost? So you would prefer only being in there?

MS. BURKE: I guess I would prefer to leave the only in, just as a modifier, until we get a handle. If staff can come up with some great alternative I'm all for it. Because I'm just where Joe is, which is, we don't want to build a system going forward that encourages everybody to be the most expensive they can be. I absolutely agree.

DR. NEWHOUSE: My problem with only is that it sounds like what we want is a system that's partially cost and partially something else. That's how I read, avoid only on cost.

MR. HACKBARTH: I think we could explain in the text that ideally you disconnect, but it may be a necessary starting point that we use some cost information. We don't want to rule that out I think is what Sheila is saying.

MR. MULLER: So we can say, based on discredited pre-prospective price --

MS. BURKE: Inflationary.

[Laughter.]

MR. HACKBARTH: In the text. We'll say that in a

footnote.

DR. NEWHOUSE: It's also not clear that -- I don't want to belabor the point -- that we wouldn't have some information. In several cases I could imagine that there would be out there in the market before Medicare makes a coverage decision and then we would in fact have some information.

DR. REISCHAUER: Maybe we should drop this bullet completely because we don't seem to know what it is that we're suggesting.

DR. NEWHOUSE: Glenn didn't want a negative in a recommendation as I heard Glenn, but in fact I think the temptation to use cost reimbursement is so strong I'd like to see it in bold-face.

MR. HACKBARTH: I think we are at the point of belaboring this point. I don't think we're advancing the discussion over where we were yesterday. So what I would suggest is that we leave only in, just to give some flexibility as Sheila has proposed, and then move as quickly as possible to a vote on this. We do have skilled nursing still to deal with and we've got some preparatory work on our June report. So we're running out of time here.

Any really urgent --

DR. WAKEFIELD: It's urgent to me, of course. Glenn, are these additional payments -- I raised this question yesterday but I had to step out of the last part of the conversation. Are we doing this in a budget neutral fashion? I want to raise that again. Is there budget neutrality in play here?

MR. HACKBARTH: Yes.

MR. MULLER: That's the current law.

DR. WAKEFIELD: Then I'd like to ask, just in text, that we have some brief discussion of how that impacts hospitals with different case mix. So in other words, that's going to have a -- that will distort or impact the relative weights of, for example, rural hospitals that may not be users of that technology if the payment is budget neutral.

MS. BURKE: Mary, this isn't new.

DR. WAKEFIELD: I know.

MS. BURKE: You just want to restate the law.

DR. WAKEFIELD: Exactly. I know pass-through payments, I know that's not new, and I know the impact. Part of the reason I'm asking this is because we getting

pretty close to the phase-out of the hold harmless and we've got lots of things going on with those hospitals. So I'd just like that reiteration in the text if that's acceptable.

MR. HACKBARTH: So it's descriptive of the consequence.

DR. WAKEFIELD: Exactly. Not asking for anything new. Just a reiteration.

MR. HACKBARTH: Anything else before we vote?

Okay, we'll do the two in order. First, the Congress. All opposed, raise your hands, please.

All in favor?

Abstain?

Then the second --

MR. DEBUSK: Glenn, one last question on the second one. That substantially improved, does that statement go in there as well, new technologies and substantially improved technology? That's in the second one.

DR. ZABINSKI: Can you just say new or substantially improved technologies?

MR. DEBUSK: Exactly.

MR. HACKBARTH: So the second bullet would be,

avoid basing rates only on cost.

All opposed to the recommendation as amended?

All in favor?

Abstain?

Okay, thank you.

DR. ROWE: From a clinical point of view substantially improved is important, because like the example we had yesterday, the stents, now they're coating them with some agent that prevents blood clots. Many people would argue, that's not a new technology; we had stents before. But it's obviously an improvement. So I think that's worth making sure that it's commented on.

DR. KAPLAN: I'm here with the three recommendations you asked that we redraft. The first recommendation I've given you two options, but actually I think the first option is the better option. The other one was an --

DR. ROSS: Sally, do we have these?

DR. KAPLAN: In copies? No, I didn't bring copies. I'm sorry. This is basically the recommendation we had last year. The Secretary should develop a new classification system for skilled nursing facility care.

DR. NEWHOUSE: What's the second bullet?

DR. KAPLAN: The second bullet was an effect of my creative last night. I'd really rather not go with it, if that's okay.

DR. ROSS: A smothered verb version of the first.

DR. KAPLAN: It just says, the Secretary should expedite development of a new classification system for skilled nursing facility care. I think if you wanted to have them expedite you could just modify the first one by saying, as soon as possible, or something on that order.

MR. HACKBARTH: I think the first one is fine, and the accompanying text would say something to the effect that we realize that the refinement of RUG-III is underway. We want to be clear though we don't think that that is sufficient and we need a whole new system.

DR. KAPLAN: Right, exactly. Draft recommendation two, if the Centers for Medicare and Medicaid Services refines the resource utilization group version three (RUG-III) and the temporary increase implemented to allow them time to refine it expires, the Congress should retain this money in the skilled nursing facility base payment rate.

MR. HACKBARTH: Any questions about that?

DR. NEWHOUSE: Could we strike, them?

DR. REISCHAUER: You sort of put it out as a possibility that the first clause could occur and the second one could or couldn't. Is that in CMS' discretion?

DR. KAPLAN: My understanding is it's not, and Murray actually confirmed that with one of the management folks at CMS who said that when the RUGs are refined, the add-on will go away.

MR. HACKBARTH: Why don't we just say then, causing the temporary increase to expire?

DR. REISCHAUER: Yes.

DR. KAPLAN: Okay.

MR. SMITH: Wouldn't it be clearer if we changed retained to add? Just sequentially, at the point that it goes away, it's not there to retain. We're really asking that Congress appropriate funds to increase the base rate by an amount equal to.

DR. ROSS: The point here was to stress that the money is in the payment now. We're trying to keep that amount of money. This isn't a suggestion to put new money in.

MR. SMITH: I don't want to play editor here, but

you can't retain it if it goes away. You don't need to retain it if it doesn't go away. We're actually asking that Congress appropriate money equal to the current add-on and add it to the base rate.

MS. BURKE: No, you do not want to be in a situation where anybody thinks there is a cost implication to this. You do not want OMB or CBO to do a base adjustment estimate. We don't want even to suggest that that money went away and came back.

MR. SMITH: I understand the concern, Sheila, but they will.

DR. REISCHAUER: If the baseline is done right, it disappears.

MS. BURKE: The point is we don't want it ever to have gone away.

MR. SMITH: Correct.

MS. BURKE: And to be added back.

MR. HACKBARTH: I could personally live with the word retain. I think it needs to be clear in the text though that there is a redistribution here. One of the implications of retain is it stays where it was, when in fact, as I understand it, it wouldn't. It just goes -- the

same amount of dollars is now spread differently across all of the rates. So I think that implication needs to be clear.

DR. ROWE: Can we just say that the base rate should remain the same; should not be changed?

MR. SMITH: It's currently an add-on.

DR. KAPLAN: First of all, it's not in the base now, but when you say you retain this money in the base payment rate it seems to me that you're saying, keep the money, put it in the base payment rate.

MR. HACKBARTH: We could say, put the same amount of money into the base rate.

MR. MULLER: Just say, the temporary increase implemented to allow -- should be kept in the base rate.

DR. NEWHOUSE: It's not there now.

MR. HACKBARTH: It is transferred to. But the distributive implications are quite different. We're taking money that was going disproportionately to the hospital-based SNF and now it will be spread across all types of SNFs as I understand it.

DR. KAPLAN: No. It really was not. It was pretty much spread among all, pretty much had the same

distribution.

MR. SMITH: Glenn, what if we said, Congress should allocate an equivalent amount of money to the skilled nursing facility base payment rate? Congress has to act here. I understand Sheila's desire to avoid the verb appropriate. But Congress has to do this. CMS can't.

MR. DEBUSK: Then retain, that's a pretty good word.

DR. STOWERS: Could we use transfer to the base rate?

MS. RAPHAEL: I like the word retain, and I might even flip it and say, the Congress should retain money from the allocated skilled nursing facility base payment rate even if the Centers -- that's what we're really saying -- even if they declare refinement accomplished.

DR. KAPLAN: So you would put the last phrase first, in other words, rather than starting out with the clause, if the Centers?

MS. RAPHAEL: Yes.

MR. HACKBARTH: David, the Congress will do what it has to do, given its procedures and baselines and all of that. The implication of retain though is consistent with

our thinking about, these are existing dollars that we don't want to go away; we simply want put in the base rate. Then Congress will have its rules. I do think it explains our intent.

DR. KAPLAN: The third recommendation, for fiscal year 2003, the Congress should update skilled nursing facility payments as follows: for freestanding facilities, update payments by 0 percent; for hospital-based facilities, update payments by market basket, and increase payments by 10 percent until an effective classification system is developed. Then the text would discuss, again, that refining the RUGs is not an effective classification system. That we're talking about a new classification system.

MR. DEBUSK: My question is, this market basket, you know when you don't receive the market basket in a given year, it's gone. It's gone. Why did we put this market basket in here? It's put in there to anticipate increase in cost from year to year. And you go back and I think this takes somewhere around that number of $60 per patient day, and X and Y takes about $32, a little over half of it. Here, because the RUG system is inadequate, we put Z in place to take care of that.

Well, our data is 1999, and we can't help that. We understand that now. But in coming forward we've got a performer that says here's really what it is possibly going to look like -- and it's a weak performer at best. Then we come along and say, you're not entitled to the market basket. That don't make sense why you continue nailing this thing when that market basket is put in place to cover these shortages.

MR. HACKBARTH: The crux of the issue, Pete, is that the staff's best estimate, which I have no reason to disagree with myself, is that the freestanding SNFs will have a 9 percent margin on their Medicare business. If we follow the logic that we did for every other provider, it is appropriate to say, they should not get a market basket increase, in my judgment.

Now the unique or somewhat different aspect of this issue that's been raised is that the total margins for SNFs, including their Medicaid business, are minus. Reasonable people can disagree about whether there is an imminent risk to Medicare beneficiaries from that minus 2 percent overall.

We discussed the issue yesterday though and the

view of the Commission as a whole, if not every individual member, was that that was not a sufficient basis for saying that we ought to give them the market basket on the Medicare side. Could be the right answer, could be the wrong answer, but it was the answer we came up with, and I don't think that continuing the discussion of it is going to be productive. So your point is understood, well articulated, but there's just not agreement.

MR. DEBUSK: I wanted my last shot.

DR. REISCHAUER: This recommendation is premised on the previous recommendation being adopted, and I wonder if we need to say that somewhere.

DR. KAPLAN: I don't really know how that would be handled, but I'm assuming that that certainly could be discussed in the text.

DR. REISCHAUER: It certainly should be in the text, at a minimum. But it's sort of stark, the zero market basket for freestandings, and you say, whoa. But what you don't realize is that relative to current law we're chucking in a significant amount of money.

DR. ROSS: We assume the Congress takes all of your advice.

MR. HACKBARTH: In this case I think Bob's right. It's worth highlighting that the two are linked.

DR. KAPLAN: Yes, they are linked.

MR. HACKBARTH: Are we ready to vote?

DR. NEWHOUSE: Do we want to add something like, in conjunction with the prior recommendation here then to explicitly link them?

MR. HACKBARTH: As far as I'm concerned we can leave that to the staff. I could either have a lead-in clause or just leave it to the text. Why don't we let them look at the whole package?

Are we ready to vote? Put up the first recommendation, please. So we're talking about the first bullet here, right?

DR. KAPLAN: Yes, that's correct. The Secretary should develop a new classification system for skilled nursing facility care.

MR. HACKBARTH: All opposed?

All in favor?

Abstain?

DR. KAPLAN: The second recommendation now reads, if the Centers for Medicare and Medicaid Services refines

the resource utilization group, version III, (RUG-III) causing the temporary increase implemented to allow time to refine it to expire, the Congress should retain this money in the skilled nursing facility base payment rate.

MR. HACKBARTH: All opposed?

All in favor?

Abstain?

DR. KAPLAN: And number three reads, for fiscal year 2003, the Congress should update skilled nursing facility payments as follows: for freestanding facilities, update payments by 0 percent; for hospital-based facilities, update payments by market basket, and increase payments by 10 percent until an effective classification system is developed.

MR. HACKBARTH: All opposed?

All in favor?

Abstain?

Okay, thanks, Sally.

The last item on our agenda is assessing the Medicare benefit package, which will be the subject of our June report. Whenever you're ready, Mae.

MS. THAMER: Good morning. For the rest of the

Commission meeting this morning we'd like to give you some background and perspectives on the Medicare benefit package.

To put the benefit package in context let me just very quickly review the original goals of the Medicare program. The first one being to limit the financial liability of older Americans. The second one being to provide health insurance coverage that's similar to that purchased by the working population, thereby removing barriers to obtaining health care.

So why examine the Medicare benefit package? First of all, the needs of the elderly may be very different today than they were in 1965. For instance, there have been changes in life expectancy --

MS. BURKE: I'm sorry, can we go back to the previous slide for just one second? This is, I'm sure, semantics, but the point is to the original goals behind the Medicare program. Even I wasn't there when they did it but --

[Laughter.]

MS. BURKE: Just let me underscore that at the outset. I was in about the fifth grade. But having said that, in fact point three, I think -- I should ask Dr.

Newhouse; he'll know. I think that it was less a question of literally just removing the barriers. It was really mainstreaming in terms then. It was really to not only remove barriers, but essentially to place them on the same playing as essentially everybody else.

MS. THAMER: Yes.

MS. BURKE: I think there's a difference -- a subtle one, but an important one, because there is a critical difference between that and what we did with Medicaid, in terms of making sure that they essentially were going into the same systems of care as the rest of the general population. So we may want to note that.

MS. THAMER: Yes, you're absolutely right. That's an excellent point.

So why examine the Medicare benefit package today? First of all, the needs of the elderly may be different today than they were in '65. For instance, among other changes there's been changes in life expectancy, there's been major technological innovations, and there's been a major increase in chronic diseases among the elderly.

Secondly, the clinical care and outcomes may be adversely influenced by the current benefit design. For

example, the lack of outpatient prescription drug benefit may affect both clinical decisionmaking and/or beneficiary behavior.

Finally, beneficiaries are at risk for high out-of-pocket cost which may not necessarily be borne equally by all beneficiaries.

DR. ROWE: Did you say that there was an increase in chronic diseases in the elderly?

MS. THAMER: Yes.

DR. ROWE: But I understanding is that disability rates amongst the elderly are actually declining substantially.

MS. THAMER: Yes, they are. They have declined.

DR. ROWE: I also believe that the incidence and the prevalence of a variety of important chronic diseases in older people is declining. So I'm surprised by the statement that it's increasing.

MS. THAMER: First, we're going to have a whole session today a little bit later on on chronic conditions and I'll go into that in a little bit more detail. What I've seen the decline has been really -- there has been a

decline in disability, definitely, which may not necessarily be the case though that chronic conditions. There may be more chronic conditions but a decline in the disability associated with the chronic conditions.

DR. ROWE: What I'm saying is -- and you may know more about this than I do because I'm just an insurance guy.

[Laughter.]

DR. ROWE: But when I last tuned into this, which was about a year ago, the data indicated that the actual incidence and prevalence of chronic conditions was declining, in addition to the severity, which would be reflected in the functional impairment. So we can take a look at this, but that is just --

MS. THAMER: We can look at that.

DR. ROWE: But let's just not accept that everything is always getting worse because in fact it may be getting better. It does, of course, suggest that they may be different than they were in 1965, which is the point of looking again.

MS. THAMER: And life expectancy has gone up, so one would expect that there might be more chronic conditions as a result of people living longer.

DR. ROWE: You don't want to debate this with me. You just want to go to the next slide.

DR. REISCHAUER: Certain people who have chronic conditions would have died earlier, and so it goes both ways.

DR. ROWE: Believe it or not, I actually understood what she meant by that. But why don't we move on?

DR. REISCHAUER: I thought you were just an insurance guy.

[Laughter.]

DR. ROWE: It's an age-specific thing we have to talk about, but the fact is -- I think the real key is here, if you want to get to this, that the dynamics of the elderly population. The old-old is growing larger, and that subpopulation has different clinical characteristics and needs than the young-old. I think that would be a way to discuss it.

MS. THAMER: Today we would like to present you with two panels. One panel will give you perspectives to think about, and the second panel will actually look at some of the perceived inadequacies of the benefit package. The

goal today is simply to provide the Commission with background information and to begin the process of examining the Medicare benefit package for the June 2002 report.

The first panel, which is sitting here, will present you with a brief history of the original design of the benefit package in '65. Secondly, the Medicare beneficiary profile, past and future trends. And third, the health expenditures for the elderly overall by payer and by type of service.

Then the second panel is going to present, as I said, the perceived inadequacies of the benefit package; financial liability and risk of Medicare beneficiaries; the care of beneficiaries with chronic conditions; and finally, primary and preventive care in the Medicare program.

Future presentations that we hope to be bringing for you in March and in April we'll be looking at changes in medical practice in the delivery of care since '65; changes in private sector benefit packages since '65; the supplemental health insurance market and Medicaid that many beneficiaries avail themselves of; and the possible criteria for changing the Medicare benefit package and what various options might be.

To start the first presentation in this series, a brief history of the Medicare program and the original design of the benefit package. Medicare was created in 1965, as everyone knows, when President Johnson signed into law the Medicare and Medicaid programs. It was comprised of three parts: coverage for hospital services which was Part A, which is paid by payroll contributions of employers and employees; coverage for physician services, Part B, which is financed by general revenues and beneficiary premiums; and finally the third unexpected part, which was coverage of low income Americans under Medicaid.

There were several salient founding principles of the Medicare program. The first one, as we mentioned, was to limit the financial liability of the elderly and their children. Each one of these I'm going talk about in a little bit more depth in a minute.

The second principle was that it was intended to be a federal social insurance program versus a social welfare program, for instance. Another major principle was the non-interference in medicine. And finally, it was a creation of an intergenerational trust fund, or social contract. So now I'll discuss each one in a little bit more

detail.

The financial liability of the elderly. Private health insurance for the elderly in 1965 was prohibitively expensive. Only about half of all elderly had any health insurance at all, and most policies were either not comprehensive, or very expensive, or both.

Access to medical care, especially inpatient services, was impaired at the time. That's suggested by the fact that there was a dramatic increase in hospital use after Medicare was enacted, and that there was concern at the time that once Medicare was enacted that there would be an insufficient number of hospital beds to accommodate the elderly because of so much pent-up demand.

Third, it was often the children of the elderly who had to assume the burden of paying their parents' medical bills. Just to give you an example, in '64, two-thirds of the elderly had annual incomes that were less than $1,500, and the average hospital stay cost $700. So you could see how very easy it would be to run up very catastrophic costs.

To talk a little bit about the theory of social insurance, which is the bedrock of the Medicare program,

social insurance evolved historically as a response to inevitable wage interruptions, and a major component is the pooling of risks across the sick and the healthy by a mandatory transfer payment system. The government usually plays an important role in most social insurance programs, and administers the program with no profit and very low administrative costs.

It's an entitlement program where only those who make contributions have a right to receive benefits. And it spreads the risk of health care costs across generations, ensuring that the very old and the very sick receive the same benefits as younger, healthier Medicare beneficiaries. Which is another way of saying that benefits are not directly tied to one's contribution.

Non-interference in medicine was the first clause in Medicare law. It allows beneficiaries to choose almost any provider. Likewise, it allows for almost any provider to participate in the program.

The original design of the Medicare benefit package was to emulate the existing private benefit packages. Like private insurance at the time, it covered only medically necessary care for the treatment of an injury

or illness. There was also limitations on coverage to primary acute care and physician services, and there was also significant beneficiary cost-sharing.

Second, there was a focus, as there was at the time, on acute medical services. There were two parts: Part A, compulsory, and Part B, which was voluntary, and they were financed separately. I think the important to note about the Medicare benefit package is that it has remained largely unchanged since '65 with the exception of selected preventive services that have been added.

I thought we would have the panel discuss -- each person would do the presentation and then we'd have questions for that panel, if that's okay.

MS. LOWE: Jack has done a great job introducing my topic here. Older Americans today are living longer and healthier lives than their peers in earlier generations. Advanced medical technology and behavioral changes have led to decline in disability among the elderly and are likely to continue. However, there are challenges ahead of us as far as demographics and economics of this population.

This picture pretty much says it all. What you see up there is the projections of the elderly population

from 2000 out through 2070 as done by the Social Security Administration. At Medicare's inception, the Medicare program served about 19 million beneficiaries. Today that number is about 40 million and expected to double again in the next years by the time we hit 2030. Today, one in every eight Americans is over the age of 65, and by 2030 that number will be closer to one in five. We can anticipate some challenges to our health care system as we look at the individuals it serves.

The fastest growing segment of the population, as Jack mentioned, is the over-85 group. Right now that number is about 4.2 million. In 30 years that should be about nine million. Interestingly, when we look at the over-85 population now, the people in that group, women outnumber men by a ratio of two to one.

Financially, older Americans are still somewhat unprepared to absorb the rising costs of health care. Gender disparities certainly persist with women lagging significantly behind men as far as their annual incomes. As you can see, that distribution of income is heavily weighted towards the low end of the spectrum compared to the general population.

Certainly, income is also influenced significantly by the age of the beneficiary. Where we see the 65 to 69 population on a family basis, their income is about $30,000. Whereas, if you look at the over-85 population that drops down to about $17,000. As a result, when you look at both the demographics of the population and income disparities, elderly women who are living longer are also far more likely to live alone on minimal income and in poverty, about 12.5 percent of that population.

MS. NEWPORT: Marian, I'm having trouble distinguishing between black and black on the bar there.

MS. LOWE: I'm sorry, those did not photocopy well. The bars to the right are the over-65 population. There was a technical photocopying challenge there.

When we look at the ability of older Americans to provide for their health care needs it depends not only on their income but also on their informal network of caregivers; primarily their spouse. In 2000, nearly half of all women over 65 are widows. Not surprisingly, more than 40 percent of non-institutionalized women live alone, compared to only about 17 percent of men.

Secondarily, the divorce and separated population,

although still a small part of the Medicare population, is growing significantly. They represent now about 8 percent of the total Medicare beneficiaries. The reason I add this up here is that for those people who were not married for at least seven years or worked 10 years of their lives, they do bear the cost of participating in the Part A program, which is about $319 a month. That is consistent with the eligibility requirements for Social Security.

Next, obviously the proportion, as I mentioned earlier, living alone, increases with age. Half of the women over age 75 live alone, and about 18 percent of the over-85 population is living in nursing homes. When we look forward at the projections, the size of the over-85 population expected to double in the next 30 years, we do see the number of Americans over 85 living in nursing homes could actually outnumber the total number of Americans over 65 living in those facilities now.

Very briefly, when we look at the disabled population that came into the Medicare population in 1973 and were about 1.7 million beneficiaries. It's just over a percentage point of the U.S. population. Today, that number has grown to 5.2 million and is nearly 2 percent of the

population. As they project into the future, we anticipate that that will be about 2.25 percent of the population by 2030. Still a very significant part, and certainly from a cost basis also something we need to look at in the future.

MR. HACKBARTH: Marian, could you help me reconcile this with the point that Jack was making a little while ago. I too have read about declining disability. Is this because --

DR. ROWE: This is non-elderly.

MS. LOWE: This is disability of the general population when we look at the non-elderly.

MR. HACKBARTH: Of course. Thank you.

MS. LOWE: Then just very briefly I want to throw up some statistics just to put all of this in perspective. Back in 1965, actually on this first data point, the number of uninsured over 65 was about 50 percent. Today that number is down to 3 percent. Medicare enrollment, obviously, has grown substantially with the size of the growing elderly population. It's still a very -- 5 million is part of that 40, for the total, so still the elderly are contributing primarily to that growth.

Life expectancy, as we look at declining

disability, has gone up significantly. There's still some gender disparity in those numbers.

One of the things we looked at as far as Medicare's ability to help us rationalize the financial liability for older Americans, looking at the percent of the population below the poverty level, as you see today, the disparity between the over-65 and the under-65 population is very minimal, as opposed to where it was in 1966. However, it is interesting to note that in 1959 the percent below the poverty level was about 35 percent. So that number was coming down already at that point.

Finally, when we look at the income spent on health care I think this says a lot. For the over-65 population we're still looking at 20 percent. Between 1966 and 2000 that number has changed very little.

With that, I'll turn to Ariel.

MR. WINTER: Thank you. We're going to be looking at health care spending on beneficiaries in a couple of different ways. One we're going to be looking at is total spending on health care services received by beneficiaries, both by type of service and by source of payment. We will also be looking at Medicare spending alone.

This slide and the next three slides include spending on both Medicare-covered and non-Medicare-covered services by all payers, which includes Medicare, Medicaid, supplemental coverage, and out-of-pocket spending. These data do not include Part B and supplemental insurance premiums.

This particular slide shows health care spending for all beneficiaries, including both the institutionalized and community beneficiaries. Just as an aside, about 6 percent of beneficiaries are in nursing homes or institutionalized.

Per capita spending on all beneficiaries was, as you can see, over $9,000 in 1998. As we show later, these average spending numbers mask significant variation in spending levels across beneficiaries. Acute and post-acute care account for about 80 percent of total spending, and nursing home care accounts for about 20 percent. The largest acute care components, as you can see, are inpatient hospital, about 28 percent, and physicians, lab, and durable medical equipment, 22 percent.

DR. ROWE: This is not what's paid by the Medicare program.

MR. WINTER: This includes both what's paid by Medicare and by all other payers, Medicaid, supplemental coverage, and out-of-pocket spending.

DR. ROWE: Drugs are only 9 percent of the spending?

MR. WINTER: That's right, by beneficiaries.

DR. NELSON: But growing fast.

MR. SMITH: This includes out-of-pocket?

MR. WINTER: This includes out-of-pocket, yes. We have data going back just to '92 by all payers and drugs, as I recall, has increased a couple of percentage points as a share of the total. I think it was about 6 or 7 percent in '92.

DR. NEWHOUSE: How do we calculate drug spending for beneficiaries in HMOs?

MR. WINTER: All the drug spending -- let me just point out that the source of this data is the Medicare current beneficiary survey. They go and survey beneficiaries about their expenditures, both made by them and by other payers on their behalf for all health care services. For non-Medicare-covered services there's a lot of filling in the gaps because beneficiaries are obviously

going to be under-reporting their expenses just by not recalling all of them. So they do do some imputations.

DR. NEWHOUSE: They're not going to have a clue what Jack pays for his beneficiaries.

MS. RAPHAEL: How do you differentiate nursing home and SNF?

MR. WINTER: A nursing home facility would not be covered under the SNF benefit. So custodial care as opposed to skilled nursing care. This obviously includes both the institutionalized and non-institutionalized beneficiaries.

Joe, I can get you more data on how they estimate drug spending on beneficiaries.

DR. NEWHOUSE: I'm not sure I need data so much as words.

MR. WINTER: We can get you those.

This chart is just the community beneficiaries, so it excludes the institutionalized. Average spending on community beneficiaries is lower, under $7,000, than for all beneficiaries, which was over $9,000. Average spending on institutionalized beneficiaries alone, which is not shown here, was over $41,000 in 1998. There's a big disparity because nursing home care is very expensive, and nursing

home residents are sicker than average beneficiaries, so they use more acute care services as well. Because there is no nursing home spending on community beneficiaries, inpatient, hospital, physician, and other acute care spending is a larger share of the total than on the previous chart.

This slide and the next slide show total spending on Medicare and non-Medicare-covered services by source of payment. Like the previous slides, these also do not include spending on Part B or supplemental insurance premiums. This slide includes both the institutionalized and non-institutionalized beneficiaries.

As you can see, Medicare, which includes both fee-for-service and Medicare+Choice, accounts for about half of spending. Out-of-pocket spending is about one-fifth of the total, which translates to average estimated out-of-pocket spending of $1,850. This figure would be higher if we added in the Part B and supplemental insurance premiums.

Dan will be talking more in detail about out-of-pocket spending in his presentation in a couple of minutes on financial liability, so if you have questions you can save those for him.

The next slide includes only community residents, so it's sources of payments for community beneficiaries. Medicare represents a larger share of spending on community beneficiaries than on all beneficiaries; 62 percent versus 51 percent. This is because we've subtracted nursing home spending, which is financed mostly by Medicaid and out-of-pocket spending. Thus, Medicaid's and out-of-pocket's share of the total dropped from the last slide to this slide. Medicaid drops from 13 percent to 3 percent, and out-of-pocket drops from 20 percent to 16 percent. Average out-of-pocket spending for community residents was about $1,100 in '98. Again, not including the premiums.

MR. SMITH: That 20 percent figure for percent of income spent on --

DR. ROSS: Use your mike.

MR. SMITH:

I'm sorry. In the previous presentation, Marian's presentation she said that the share of income devoted to health care expenditures had changed very little; '65 to 2000 had stayed around 20 percent. That 20 percent does include the premiums that are excluded from this data; is that --

MS. LOWE: I believe that does reflect this.

MR. WINTER: This slide takes a closer look at how Medicare spending alone is apportioned. The largest shares of Medicare spending go towards inpatient hospital at 48 percent, and physician, lab and DME at 27 percent. Average spending per beneficiary was $5,340 in 1998. This was based on CMS and Medicare trustees' data.

However, a small proportion of beneficiaries accounts for most Medicare spending, as we'll see on the next slide. So this chart gives you an idea of how skewed Medicare spending is. This shows that just 6 percent of beneficiaries account for half of total fee-for-service spending. That's the top of the left bar and connected to the top of the right bar. Then 35 percent of beneficiaries account for just 1 percent of total fee-for-service spending. They spent less than $500 per person.

DR. ROWE: I'm assuming you're aware that the point here is that this is in fact less concentrated than the entire population. In the entire population of my 20 million customers, 6 percent account for 66 percent, I think, of the expenditures; not 50 percent. So in fact, in the elderly population there's less of a concentration, not

more of a concentration. That's the point.

DR. NEWHOUSE: The decedents are in here; is that right?

MR. WINTER: I would assume so. I will check on that. I would assume so.

DR. ROWE: But some of these things you might want to compare it to the overall population.

MR. WINTER: That's a good point. We'll work on that.

DR. ROSS: Jack, it also reiterates why risk adjustment is so necessary in this population as opposed to the commercial population. It's more predictable here. Jack's got his small group of random spenders.

MR. WINTER: That's my last slide so I'll it back over to Mae for any questions.

DR. ROWE: I have a couple points that I'd like to offer. I think that there are two general points about the changes, trying to focus on the changes that have occurred over the last decades. One is the point that Bob was referring to when he was talking about, there are more of them -- there are more of these people and they're living longer, so there are more cases of these diseases. I think

that what I would offer you is a couple things.

I think you should make a clear distinction between the disability rates, which are going down, and the number of disabled elders, which is going up. Because the number of old people has doubled and the disability rate has gone down 25 percent. So that there are more disabled elderly people in the community than there were. So you have to try to clarify the difference between the changes in the size of the population, particularly in the old-old, and the rates, et cetera. I think it would be helpful.

The other is to give a couple specific examples of diseases. For instance, I believe -- I'm going to make these numbers up -- that the prevalence of Alzheimer's disease at age 65 is in the 5 percent range, maybe 5 to 7 percent. At age 80 it's in the 40 to 45 percent range. So obviously, as you get more people who are in the old-old group, you get many more people with Alzheimer's disease.

The same thing with hip fracture; a dramatic, dramatic increase. The answer to hip fracture is, if you could delay the onset of hip fracture by five years you'd prevent half the hip fractures, because people would be dead before they had their hip fracture.

So I think that a couple of these dynamics, of showing the different age-specific incidences of diseases, so that people just don't think there are young people and then there are old people and all the old people are the same. So I think that that's one thing that you might put in.

A second thing that you might consider putting in is that not only have old people changes, but health care has changed. For instance, in 1965, my guess is that not too many old people had cardiac surgery. It just wasn't -- you know, why would you operate? Why would you operate on -- you know, people had this idea, the average life expectancy was 70. Why operate on a 75-year-old?

As the technology advanced, and the safety improved, and the mortality rates in the elderly with good anesthesia reduced, the permeation of many of these technologies into the elderly population was dramatic. I think that's one of the major factors that's driven up cost. Health care for older people in America, even if the elderly were the same and hadn't changed, is different than it was in 1965. So it's not only about the elderly changing. I think it's about our health care system changing, and

technology. I think that might just be helpful to think about considering.

DR. REISCHAUER: I agree with what you said but I want to correct your misinterpretation of what I had said earlier, which is in 1950 people with heart problems had a heart attack and died at age 55. Now we operate on them, we give them drugs, and they have a chronic condition. So the fraction of people with certain conditions can go up. I was talking about the rate, not the absolute numbers. Although in general in other areas they go down.

MR. FEEZOR: David had highlighted, bracketed, I think the fact that was presented in Marian's that just struck me. That was actually the two bottom lines on that last slide, sort of then and now, in '65 or '66. Even though we had basically the number of people over 65 in poverty drop by about two-thirds, the fact that the average spending, out-of-pocket spending still actually remained about the same or went up.

That probably tells me, not only I think in Jack's point in terms of how much more health care that we are consuming, but in fact that despite some of the original intent they probably have more people getting more access;

that's better care. But the reality is that the financial burden on our senior citizens, even though they are hopefully, would appear more or better off at least by definitions of federal poverty, that in fact there still is that almost same financial burden. It says something about maybe our design, maybe our coverage, maybe how care has shifted. But I just felt that those two last lines were terribly, terribly powerful in terms of the need to revisit some things.

MR. HACKBARTH: So a big part of Social Security is a transfer to health care providers, in effect. So it's increased their incomes but a big hunk of it is going to higher health care costs.

MR. SMITH: But it is important to remember here that that 20 percent is buying a lot more health care.

MR. FEEZOR: Absolutely.

MR. SMITH: I agree with Allen's point, but I want to make sure we get the other point. It might be useful to have a then and now consumption pie chart, as you have for current consumption, because we don't want to suggest that people are paying 20 percent and getting the same health care they were in 1965.

DR. REISCHAUER: But also there's the issue, if not health, what? Skiing vacations, hang-gliding? Think of this, the fraction spent on food, on clothing, on housing has declined in America. You've got to spend it somewhere. The rest of us are doing it on compact disks and skydiving lessons. I don't want the 65-year-olds out there doing that.

[Laughter.]

DR. NEWHOUSE: Not to mention child care.

MR. MULLER: But in terms of the predictors of what it will cost is Jack's point about the old-old going up much more disproportionately than the young-old, is that going to be the -- it strikes me that's a big driver in terms of what happens than perhaps the shifting -- the other point that there's more medical interventions available right now.

DR. NEWHOUSE: There's a difference between Medicare and non-Medicare. Medicare by age is actually much flatter than total by age because of the greater incidence of nursing home at old age which isn't covered. Correspondingly, the less tendency to do aggressive intervention among the very old in the covered services.

DR. ROWE: Right. With each additional year the actual per-year expenses fall with advancing age, right? Isn't that what the HCFA studies have shown?

DR. NEWHOUSE: The last I saw, which was now quite a while ago, it was a very shallow inverted U starting at age 65 with a peak around the mid 70s to early 70s.

DR. ROWE: I guess what I was saying is that the projected increases in Medicare expenditures were, over the next decades were dramatically driven by the number of elderly, not the increase in life expectancy. Because the actual increase in life expectancy had a very modest effect on increasing overall expenses.

DR. NEWHOUSE: Right, and also the increase in just cost; the amount of services that we expect we will have to deliver and how expensive they will be per elderly is also a big driver.

DR. ROWE: Is it Lubitch who did this work when he was at HCFA?

DR. NEWHOUSE: He certainly did the work on cost of care at the end of life.

DR. NELSON: I think in a discussion about the benefit design, not only the reality of these changes but

the changing expectations of the beneficiary population are important to consider in any kind of future planning. There is a greater unwillingness to pay for predictable expense, which was part of the original concept of insurance: things that you could predict were going to happen, you accepted the burden of paying that yourself, much more it seems than the current Medicare population is willing to do. At least from the changes in legislation that have provided predictable preventive services that certainly is a reality.

There's also, I believe, not the acceptance of care being provided by the family, particularly home care to the degree that there was. My expectation is that the rejection of the notion that it's the obligation of the family to provide the kind of domiciliary care that was part and parcel of the culture a couple of decades ago is probably going away.

Finally, I think that as the boomers age there will be a rejection of the notion of limitation being a part of life to the degree it has been in the past. That is, if they can have cosmetic surgery, they're going to want cosmetic surgery. If they can walk without a limp, it's no longer part and parcel of being elderly to have a limp and

they want to get rid of the limp.

So I think the expectations are changing, will continue to change, will continue to be an important part of increasing utilization and this needs to be taken into account as we look at the benefit.

DR. ROWE: I think that one other change that has occurred -- I agree with Alan's point of adding expectations in addition to changes in the practice of medicine, in addition to the changes in the nature of the population. I think a final one that I could think of at this point was that in 1965 there was basically nothing known or written about health promotion and disease prevention late in life. Health promotion was a pediatric initiative. It was about vaccinations. Then there was cholesterol in middle age and things like that. But the concept of health promotion late in life really was not a part of medical knowledge or training. When people started talking about it there was a lot of resistance to it.

Now I think there have been, as Mae pointed out, a number of preventive things added. But that was not the initial intent of Medicare. One of the problems on getting more prevention stuff in is people always point to the

founding legislative language and they say it's about the treatment of disease, not about the prevention of disease, et cetera. It's always an uphill fight. And there are lifestyle issues about smoking cessation, and exercise, and weight maintenance and other things that are just not benefits, if you will, and maybe they shouldn't be benefits. It's a different discussion.

But I think that the management by the average physician of the average elderly individual in America, say a 67-year-old individual, includes an awful lot more prevention-oriented activities now than it did in 1965. I think that should be included in this chapter as one of the secular changes, if you will, in this population that might urge some consideration about what a future benefit package should look like for this population.

DR. WAKEFIELD: This is really a nice opportunity I think for us to step back and maybe infuse a little bit of new and creative thinking when we think about Medicare. So we're talking about financing and the benefit package, but I'd also like you to think for at least two minutes in your spare time, of which I know you have none, to think a little bit about what, if anything, that might be some lessons that

we could incorporate in our thinking in terms of structuring the care for Medicare beneficiaries that ultimately finds its way into that benefit package.

And a place I'd go to look for some of that thinking would be in the Institute of Medicine's Crossing the Quality Chasm report. There's a lot of discussion there, for example, about meeting chronic health care needs, and ways of doing that. At least some fairly new ideas I think in terms of prioritizing and reconstructing health care delivery for individuals with chronic care; a big part of what we're talking about today.

Also there's a lot of discussion about the use of information technology and communication vehicles. I think Alan maybe yesterday had made some passing comment about physicians communicating with e-mail, and nurse practitioners, and psychologists and others, I would add, perhaps communicating by e-mail with their patient population. So there is a discussion of information technology there that may have some relevance to our thinking about this huge program, Medicare, that can help set the stage for how health care is delivered.

Just the last example I'd say is, there are

discussions there about putting into place systems that facilitate or that provide clinicians with tools to operate from an evidence-based practice. That too is an important to a Medicare beneficiary that enters a health care delivery system.

So given that this is an opportunity to step back and do an assessment, I'd like, to the extent you can, recognizing what the real focus might be here, issues around financing and the actual specific benefits, if there's a way of stepping back a little more broadly, that I think would be an excellent source of some ideas that might be relevant to Medicare beneficiaries. So I'd encourage you to look at that if you haven't yet.

DR. STOWERS: Just building on what Mary is saying and being in practice taking care of a lot of geriatric patients, as they switch over, and looking at the demographics, there's a huge percentage that end up depending on Medicaid. There's a lot of federal dollars that flow through to create that Medicaid benefit. But having been on the border of two states, there was tremendous inconsistency between the way that Medicaid took care of that age group and their chronic care needs.

I'm wondering if we relook at this package, is that the best way to pass out these federal dollars through individual programs with all the state variability and regional variability and what care they receive? So I think one other thing, building on what Mary says is, we need to look at that variability in that stage and see where we're headed with it.

MR. HACKBARTH: Okay, should we move to the next part?

MS. THAMER: Our second panel will be discussing the perceived inadequacies in the Medicare program. One of them that we touched on quite a bit already has been the needs of beneficiaries with chronic conditions.

Looking at the prevalence of chronic conditions, according to one study, as many as 90 percent of Medicare beneficiaries have at least one chronic condition, and 70 percent have more than one. Now this is using a very broad definition of chronic condition. The definition that's usually used in these types of studies are that it's a condition that has lasted 12 months or is expected to last at least 12 months, and that it either requires ongoing medical care or it results in functional limitation. So as

a result of a relatively broad definition you have statistics such as these.

What's more important is that chronic conditions vary in severity, as we'll discuss a little bit later, and that they have the potential to curtail functional status and the ability to live independently.

This chart shows the most common chronic conditions among those over 70. As you can see, the prevalence of each of these conditions, with the exception of hypertension, has increased from '84 to '95. To give you a sense of how severity can vary, however, bear in mind that while 58 percent of beneficiaries over 70 report having arthritis, only about 11 percent report arthritis of a cause of a limitation in their daily living. Likewise, while 21 percent report having heart disease, 4 percent report heart disease as a cause of a limitation in daily living.

Now having seen -- next chart, please. This overall shows you the percentage of Medicare beneficiaries 65 and older who are chronically disabled. Overall in 1994, 21 percent of beneficiaries who were 65 and older reported some level of chronic disability. That is, they're having difficulty with at least one instrumental activity of daily

living, or activity of daily living, or they were institutionalized.

To remind the Commission quickly, IADLs include trouble with housework, laundry, preparing meals, shopping for groceries, et cetera. ADLs include eating, getting in and out of bed, getting around inside, dressing, bathing, et cetera.

This chart also shows a decline in the level of disability from 24 percent in '84 to 21 percent in '94. The source of this chart is the national long term care survey, which has been done several times in the '80s and in the '90s. Several other surveys have also shown a decline in rates of disability, including the share of elderly living in nursing homes which has fallen.

It's been speculated that the decline may be due to medical care improvements, for instance, joint replacement, cataract surgery, introduction of new drugs. It might also be due to changes in health behavior, the most salient one being a decline in smoking, or increased use of assistive devices like walkers, canes, handrails, et cetera.

Now the recommended care for chronic conditions has many aspects to it. One of it would be -- the first one

is an interdisciplinary team assessment. This allows for flexible and individual patient needs. A second major component is the early detection of functional impairment. There are many simple interventions that can slow or prevent functional loss. These can be detected using routine physical exams or preventing vision and hearing loss.

The third one that's been mentioned is the use of proven, evidence-based treatments. Another crucial aspect is the support for patient self-management. Additionally, the appropriate use of medication. Then finally, assistive devices for mobility, hearing, and vision.

With regard to mobility and rehab in general, it must not be contingent on only showing improvements, but it should also be appropriate for maintenance, to prevent further decline, which is something that there's an issue in Medicare reimbursement. Hearing loss affects 40 percent of the elderly. That can lead to isolation and withdrawal from the workplace and decreased productivity. Vision loss can lead to near total dependence, without treatment. And both vision loss and hearing loss are major risk factors for depression among the elderly.

The recommended care, however, for chronic care is

not always delivered. This applies to the health care system as a whole and is not just an indictment of the Medicare program. Care if often fragmented, with little communication across settings and providers, both between medical providers and between medical and non-medical providers. Treatment regimens often do not conform to evidence-based guidelines. In a recent study it showed that fewer than half of U.S. patients who have hypertension, depression, diabetes and asthma receive appropriate treatment.

Finally, providers typically devote insufficient time to assessing function, to providing instruction on behavior change or self-care, and to addressing the emotional and social distress of patients who have a chronic condition.

Medicare's ability to promote quality chronic care is limited. The basic benefit package under Medicare Part A is still organized around a spell of illness which by definition is time limited. High quality chronic care, on the other hand, requires continuity and stability over time. Also, Medicare is an individual entitlement. While it is increasingly understood that serious chronic illness is

something that happens to families and that effective patterns of care address both the patient and the families and the caregivers.

Specifically, Medicare doesn't cover, but provides only limited coverage for certain important care for the treatment of chronic conditions; for example, prescription drugs, case management. And that fee-for-service Medicare doesn't promote coordination and continuity of care.

To give you an example of how important coordination of care might be, an analysis of Medicare claims data suggested that the average beneficiary who has one or more chronic conditions sees eight different physicians in one year. So coordination of care is really quite vital. Current Medicare policies do not reimburse for telephone or other provider-patient interactions that aren't face to fact. It doesn't reimburse for care of patients in group settings, or many patient education activities, despite the demonstrated efficacy of such interventions.

Finally, there's higher out-of-pocket spending among the chronically ill. Beneficiaries with three or more chronic conditions spend nearly three times more than what's spent out-of-pocket by those who have no chronic conditions.

In general, there's roughly a linear relationship between the number of chronic conditions that you have and your out-of-pocket spending, in a recent study. The largest expenses are for prescription drugs, dental services, and office physician visits.

To put it in perspective a little bit, almost one-fourth of all single elderly living alone that have one or more chronic conditions, they have spent more than 10 percent of their income on out-of-pocket health expenditures. For senior couples, that's about 18 percent of them spend 10 percent or more.

I think that's a nice segue into Dan's presentation.

DR. ROWE: May I make one point with respect to this, if I may? First of all, I think this is really excellent. I would only want to add one consideration. That is, I think that many people misunderstand the nature of health care utilization by chronically ill elderly. The point to be made is that most of the expenditures are for acute care.

You look at these diseases, heart disease, chronic disease, most of the expenditures are an acute

hospitalization for congestive heart failure, or worsening angina, or an arrhythmia. People with hypertension who have a chronic disease, most of the expenditure is they get admitted to the hospital because something happens. Osteoporosis is a chronic disease, but hip fracture is an acute complication of it, if you will. Cancer, people get admitted to the hospital with cancer when they have an acute problem. Diabetes, people get diabetes out of control and they admitted.

So it's the acute complication of an underlying chronic illness. When you look at the utilization of the health care resources and Medicare spending and you categorize it as acute or chronic, most of the people or many of the people who use the acute resources are people who are chronically ill. So it's really not a different category of utilization.

It tells you something about pathways to reduce acute utilization, and that's why disease management, patient management programs are something that perhaps Medicare should consider because it's by managing the chronic illness, not only do you improve functional status, which you said, but you reduce acute care utilization. It's

not all just about function. I think that idea might be something you might consider including.

But this is really very nice.

DR. ZABINSKI: Today I'm going to discuss positive aspects and perceived problems of the Medicare benefit in terms of beneficiaries' financial liability on medical care. Now the Medicare program has had some positive effects in reducing beneficiaries' liability. Prior to the Medicare program many elderly had no health care coverage, or poor coverage. Now the elderly have nearly universal coverage under Medicare.

Moreover, the program pays most of the cost of Medicare-covered services, paying about 80 percent of those costs in 1998 for example. In dollar terms, this translates to the program spending about $4,200 per beneficiary among those who participated in fee-for-service Medicare for all of 1998. This coverage improves beneficiaries' access to care by making care less costly.

Now despite these positive effects, many are concerned that beneficiaries face substantial financial liability problems. Sources of these perceived problems include first of all, cost sharing for Medicare-covered

services in the form of deductibles and coinsurance. Furthermore, Medicare does not have a catastrophic which is an attribute of most private health insurance plans.

Second, many believe that Medicare does not cover some important services, including outpatient prescription drugs and long term care in facilities, particularly nursing homes.

Now earlier I mentioned that Medicare pays 80 percent of the cost of Medicare-covered services. However, when we also considered services not covered by Medicare we found that the program pays only 50 percent of the cost of all services, including long term care again. Beneficiaries are liable for the main share. Moreover, the combined effect of cost sharing and uncovered services on beneficiaries out-of-pocket spending can be substantial.

On this diagram here we show average out-of-pocket spending in 1998 by beneficiaries living in the community, those living in facilities such as nursing homes, and the two groups combined. The first two columns of numbers indicate that for both the community and the nursing home populations, out-of-pocket spending on uncovered services is larger than out-of-pocket spending due to cost sharing on

covered services.

Average out-of-pocket uncovered services is especially large for the nursing home population, about $12,500 per year, and about $300 of that amount is long term care in facilities. In the community average out-of-pocket on uncovered services is much smaller than what it is for the nursing home; it's only $940 on average. But it's still much larger than the average out-of-pocket due to cost sharing, which is only about $210. Amongst the community population, the largest components of uncovered care are on prescription medicines and services provided by providers and their supplies.

Finally, in the third column we have displayed out-of-pocket costs of premiums which combines the Medicare Part B premium with premiums for supplemental coverage such as Medigap. This column indicates that the premiums contribute heavily to out-of-pocket burden in the community, averaging nearly $1,200 per year. I think it's important to note that supplemental coverage substantially reduces beneficiaries' out-of-pocket spending, paying for about 61 percent of the cost that beneficiaries are liable for.

Now a significant effect of the supplemental

coverage on beneficiaries' out-of-pocket spending on services is due at least in part to most beneficiaries having supplemental coverage. In 1998, 89 percent of beneficiaries in fee-for-service Medicare had some sort of supplemental coverage, and that includes Medicaid.

One of the benefits of supplemental coverage is it reduces beneficiaries' risk of catastrophic loss. For example, 19 percent of beneficiaries were liable in 1998 for health care service costs, including long term care, in excess of $5,000, but only 7 percent had out-of-pocket spending greater than $5,000.

Despite this benefit, supplemental insurance does have some disadvantages. First, it can be fairly costly for beneficiaries to obtain. Average out-of-pocket spending on supplemental premiums was about $700 in 1998. Second, this is often an inefficient way to supplement Medicare coverage because administrative costs and Medicare premiums are typically quite high. Finally, supplemental insurance often pays deductibles and coinsurance for Medicare-covered services, making beneficiaries less sensitive to the marginal cost of care which conceivably could cause them to overuse care.

Now Tim's going to talk about primary and preventive care services.

DR. BRAUN: I've been concerned about the premiums on Medigap. Does that average employer-retiree premiums or just Medigap premiums? Because it seems to me they're much too low.

DR. ZABINSKI: This includes any sort of -- it's an average, first of all, and it includes any out-of-pocket expenditure on supplemental coverage. That includes Medigap, that includes some contribution to an employer-sponsored plan. One thing I think maybe to add is that, I looked at the distribution in this out-of-pocket as well and up at the upper tail, for example at the 95th percentile, the out-of-pocket is about $2,300. So it gets to be pretty high in some cases.

DR. BRAUN: It goes way up. For instance, if you only do Plan A on Medigap, which is the cheapest one, at 65 I've got two of them, one is $768, the other one is $858. At age 75 they go to $1,380 and the other one says $1,098. So they're fairly high even for Plan A. So if you consider them all at 65 that would be a different thing. You get up to J and you're over $5,000 at age 75 or higher. So they're

terribly high.

DR. REISCHAUER: This is all premiums paid divided by all people.

DR. ZABINSKI: Exactly.

DR. REISCHAUER: So it has people who are on Medicaid and aren't paying anything for premiums for supplemental. It has people who are employer-sponsored where the employer pays 100 percent of the premium, or some others that pay -- so this really isn't a number that --

DR. ROWE: It's not a meaningful number.

DR. REISCHAUER: I think you're right, it gives the wrong impression --

DR. ROWE: There's a lot of zeroes averaged in there.

DR. BRAUN: So you're dividing by the number of population?

DR. REISCHAUER: Of Medicare beneficiaries, yes.

DR. ROWE: It's the Medicaids and the QMBs and the SLIMBs.

MR. HACKBARTH: So Bob's agreeing that this number is not an accurate reflection of the typical burden felt.

DR. ZABINSKI: Just doing a back-of-the-envelope

calculation, if you include only the people who have supplemental coverage I think you come out to about $1,000 on average.

DR. REISCHAUER: But half of those are employer-sponsored where the employer is subsidizing 60, 70 percent of it.

DR. ZABINSKI: Actually over half of them are -- about 60 percent of people who have supplemental, it's employer sponsored.

MS. NEWPORT: I'm going to the same point here, is I think it's important as you amplify on your work that we have that properly clarified in terms of what percentage is purchased individually, what percentage is covered by retiree plans, what percentage may be Medicaid, SLIMBs, QMBs, that sort of thing, because I think that's important.

The other issue here, because your focus is the right focus though, is that what we're missing is, in the market for Med supp products, not in every area, A through J is not available.

DR. BRAUN: That's right.

MS. NEWPORT: So within that is a prescription drug deductible or cost coverage included, and to what

extent can you wrinkle out that issue? So I don't know if the data is available. I know that there's some market analysis out there.

But I think that, at least anecdotally I've been told that over time there's been an erosion in availability in the breadth of these products. And the other part of this is guaranteed issue at certain points. In lieu of just straight fee-for-service, and some demographics we know you might not have employer coverage, you might not have A through J, you might not be able to afford it because of your age or whatever, and change in status.

So I think it's becoming increasingly complicated, just to make your lives full and everything. But I think that we don't want to miss a really important aspect of what really is covered in total and then what the out-of-pocket costs are. If you can tweak that out I think it would be very helpful.

DR. ZABINSKI: I've always thought it would be really useful to look at things by breaking out by what type of Medigap coverage they have, but in our database there's no indication of whether it's A, B, through J. We can separate by whether it's employer or individually purchased,

but that's about as far as we can go.

MS. NEWPORT: Are there industry sources for that data?

MS. THAMER: Let me just say that we hope next time to come back with a much more detailed report on trends in Medigap coverage, trends in retiree, Medicaid, whether there is or isn't an erosion in what's being offered, and have the premiums gone up. So we should be able to get you a lot more detail then. Because we realize it's very important and we just touched on it superficially today.

MS. NEWPORT: As usual, you're ahead of us on most of these things.

DR. WAKEFIELD: Can I just say in terms of looking at out-of-pocket costs for beneficiaries I think we had some data, maybe from AARP, in the June report that looked at rural versus urban Medicare beneficiaries, if we could also incorporate that piece into it, please.

MR. GREENE: Good morning. I'll very briefly go over a summary of where we are as far as looking at preventive services, which as we've said is the major change in the benefit package in the last 30 years.

Initially Congress limited Medicare coverage to

services that are reasonable and necessary for diagnosis and treatment of illness and injury. Beginning in 1980 with coverage of pneumococcal vaccine, Congress expanded coverage of preventive services. This overhead is a selected list of important services covered over time. It's not comprehensive. There's more information in your briefing material.

After coverage of pneumococcal vaccine in the 1984-'91 period we saw expansion to hepatitis B vaccine, flu vaccine, pap smear, and the first coverage of mammography for cancer screening. In 1997 the BBA provided the largest expansion of preventive services to date, including colorectal cancer screening and PSA for prostate cancer screening, and despite some controversy, osteoporosis screening provisions. Finally, BIPA the year before last added further expansion.

How do we assess both the historical and recent expansions? First, an independent body designated to review and recommend preventive treatments is the U.S. Preventive Services Task Force of Department of Health and Human Services. The task force follows rigorous standards in determining which services have clinical benefit, although

it explicitly doesn't look at cost effectiveness criteria, just clinical benefit as a standard.

We compared the services recommended by the task force for those 65 years of age and older with those covered by Medicare and we see a reasonable amount of consistency, though the program doesn't cover all recommended services for the elderly. For example, the task force recommends and Medicare covers flu and pneumococcal vaccine and pap smears. Similarly, the task force does not recommend coverage and Medicare does not cover screening for lung cancer and cholesterol.

On the other hand, we do see some inconsistency. As indicated, osteoporosis screening is not recommended but it is covered by Medicare. Congress found that desirable. On the other hand, the task force recommended but the program doesn't cover counseling for smoking cessation and diet or exercise improvement.

Now another basis for judging covered services is comparing Medicare with services offered by private plans. Here again we see a certain amount of consistency and a certain amount of difference. Once again, both private plans typically cover and Medicare also covers mammography

and pap smears. Incidentally, when we said private plan covers we mean, in a survey approximately 90 percent of plans offered this services. When we said they don't cover it, 25 percent or fewer offer the service.

Again, we see common patterns for mammography and pap smear, and also common patterns with the counseling, behavioral change services, smoking cessation and so on. Both not covered by either the private sector or by Medicare. We see some difference in things like routine physical and gynecological exams which are typically covered in the private sector but not by Medicare.

Finally, we do see that despite coverage limitations many of the elderly receive some services that are maybe desirable in some ways, but are obtained regardless of coverage rules. Although routine physicals are not covered by Medicare, approximately 90 percent of the elderly, even relatively old, report having received physicals within the last two years. The same is true for other services.

On the other hand, we can see that coverage is not the key for obtaining preventive services in a different sense. That a variety of factors, insurance coverage,

education, age and other factors seem to have played an important role in whether individuals seek out and obtain services that may be of benefit.

In the first category, for example, we see that members of Medicare+Choice, who obviously have more complete coverage of many services, use the typical preventive services more consistently. We find beneficiaries with lower levels of education, though it's not as consistent, with higher age to be less likely to use a variety of services.

Finally, both in the under-65 and among the elderly we find that availability and use of information, exposure to education campaigns of the sort that CMS operates and so on, also increase service use. It might be noted that the heavy use of services by members of HMOs, Medicare+Choice plans may be partly due to the promotion of these services and the information provided to beneficiaries in those plans, apart from the pure insurance coverage aspect.

Finally, that leads us to suggest that if we're serious about expanding use of preventive services that might be of benefit to the elderly we want to look beyond

pure coverage policy to a variety of additional policies. Some such as reduced cost sharing have already been pursued by the Congress. Many of these services, the vaccines and so on, are provided with zero coinsurance now, but other efforts of outreach and beneficiary education might also be pursued.

DR. BRAUN: I just wondered where you got the information on the physical exams? The reason I'm asking is I'm just wondering how many of those people don't have anything else wrong with them and therefore there's no Medicare reimbursement for that physician visit. I would not think that's very high.

With the number of chronic illnesses and the fact that physicians usually go through the whole person, if they're an internist particularly, if the person comes in for a visit -- that the patients themselves might think they had a physical in the sense that you're asking. I just wonder how many people with no other illness over 65 are going in for physicals.

MR. GREENE: I don't know. That's based on survey data, health interview survey and other sources, not from

CMS data that allows us to say very much about the nature of the individual. Those are very basic statistical profiles of the elderly, so we really can't say much about the characteristics of these people.

DR. BRAUN: So they're just asking the question, have you had a physical exam --

MR. GREENE: Yes, with some demographic detail but without diagnostic and medical detail.

DR. ROWE: Just a couple points. One is, I think you should include a general description of different kinds of preventive services, primary prevention, secondary prevention.

MR. GREENE: We have it in some of the text, yes.

DR. ROWE: I think that this is an opportunity to address the M+C programs a little bit, because one of the things that the M+C programs offered was the preventive orientation that the HMOs brought to the table, and that was one of the things that was presumably attractive to some of the beneficiaries. They liked that in addition to the other benefits like eyeglasses and pharmaceuticals, et cetera. So I think that you might see if you can get some history on that, or at least mention that some Medicare beneficiaries

had access to more preventive services through that program than they may have through the other program.

The third thing I'd say is just as a general summary of this field I think this is really excellent.

DR. WAKEFIELD: Could I just tag on to his first point, Jack's first point? Just to the extent, I agree to provide that history would be appropriate in terms of coverage. But would you also then, if you do that, please incorporate what it is that rural Medicare beneficiaries; i.e., all of North Dakota's elderly, for example, don't have access to, and that is they do not have access to M+C, using that as an example. So what implications that has for a proportion of our Medicare beneficiaries and their access to preventive benefits compared to their urban counterparts.

MS. NEWPORT: Tim, I don't know how readily available the data is but it sort of builds on the last two comments, is what I'm trying to do. For example, we might not cover smoking cessation directly in the plan because, let's say the rate. But we have been able in some areas to negotiate discounts with Smokenders, if I can use a proprietary name here. So that we've used a variety of explicit and implicit devices to offer a wellness benefit to

the extent that we know that it accrues to the beneficiary.

So sometimes it will be directly in the benefit packages, but sometimes it will be as an option you can get a better rate on some of these programs. We have trouble explaining this to the regulators sometimes, including joining health clubs and things like that. But it all works together in the aggregate. You may just need to sit down and talk with the industry a little bit; amplifies that if we can't do it explicitly we have these other programs that we can funnel people into at less cost to them out-of-pocket.

smoking cessation

MR. HACKBARTH: Any other comments?

DR. ROWE: Just one general comment. In looking at these two panels, one area that I think might not be currently covered, although it may be and I missed it, that we might consider is the emergence since the program was developed of special populations within the elderly; the frail elderly, the PACE programs, et cetera. That the provision of health care services to these populations has changed over these 30 years. These new programs have been developed; the SHMOs and the PACEs. I think that that's a

reflection in part of the growth of the over-85 population. But the care at the end of life, frail, et cetera, might be something that might deserve some attention.

MS. NEWPORT: The other issue and you talk about it earlier in your presentations has to do with management of depression. There are quality programs and disease management programs that some of the plans have that sort of envelop the chronic conditions with management of depression, which has better health outcomes. So I think that that needs to be more explicitly talked about at some point. It's of extreme value.

MS. THAMER: So as a comorbid condition, depression. Because we don't want to get into anything disease specific because then we'll be talking about totally unique conditions. But as a comorbid condition to chronic conditions in general.

MS. NEWPORT: That's right. But our identification within our program of that, incorporating it very affirmatively in our disease management programs has had a very, very positive outcome, recognizing that in terms of depression and its effect on people being able to get well, stay well, is very important.

MR. SMITH: Just one last set of questions, Tim. All of you, like my colleagues I found this very, very useful. Tim, I wonder if there isn't -- and maybe it's just not useful, but we've got some information about determinants of use -- availability of insurance, education, which may be a proxy for income -- but I wonder whether or not income is not independently important.

The other question that I wondered as I looked at that was, are there distinctions between -- and Mary raises one of them -- geography. But are there age, gender distinctions between users that are independent of things like insurance and education? Does it matter where you live? Does it matter how old you are? Does it matter what your social circumstance is? Are you alone or --

MR. GREENE: Income doesn't appear to matter.

MR. SMITH: And certainly insurance and education are probably a reasonable proxy for income, but I would appreciate if we could take a look at to what extent income matters and how that shows up.

MR. HACKBARTH: Last one, Ray.

DR. STOWERS: I think too that reminds me of the fact that there's a lot of -- especially when it comes to

rehab -- corrective shoes, all sorts of things that are left up to the discretion of the local carrier. How much does the benefit package really vary per the different regions?

Like I said, I was in two regions where our practice is and there was a lot of difference in some of those benefits and the packages. So somehow that may need to be looked at, or what that discretionary difference in the benefit package is.

MR. HACKBARTH: Thank you very much. Good start on this. It's now time for our brief public comment period.

[No response.]

MR. HACKBARTH: Okay, that was briefer than I had expected. Thank you very much.

[Whereupon, at 12:06 p.m., the meeting was adjourned.]