MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 8, 2005, 9:51 a.m. *

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
FRANCIS J. CROSSON, M.D.
AUTRY O.V. DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

* December 9 proceedings begin on page 253

P R O C E E D I N G S

MR. HACKBARTH: Okay, we're going to get started. We are going to begin with a discussion of the mandated report on payment for oncology services.

But before we delve into that, we have a large number of for presentations over the next two days directed at assessment of payment adequacy and ultimately moving towards update recommendations.

Let me just say a word or two about that process. We take our final votes on update recommendations in January for inclusion in the March report. Today and tomorrow we will have presentations from the staff that include draft recommendations on update factors for various sectors. Those draft recommendations, for the most part -- and there are a couple of exceptions which I will come back to in a second -- but for the most part they simply represent what we recommended last year for that particular sector.

So I urge people in the audience to look at them in that context and not read it too much into them in terms of what they may mean for what the Commission ultimately recommends in January.

There are exceptions to that. There are a couple

sectors that are new for us. This is the first time we will be making update recommendations, and those are long-term care hospitals and inpatient rehabilitation facilities. So there the draft recommendations are not simply last year's recommendation. That's new.

And then there is one area, the physician update, where in fact there will be no draft recommendation. We are in an unusual position there in the sense that there's still uncertainty about what the update would be for 2006, and here for our March report we are trying to recommend an update for 2007 and we don't even know the base that we'd be working from, which complicates the task. So there will not be a draft recommendation at this point on the physician update.

As always, we will have our public comment period at the end of the morning and afternoon sessions. Those are more widely used during the update season, so let me in advance talk a little bit about the ground rules there.

We urge people to talk only about the issues that were brought up in that session, as opposed to some they anticipate will come up tomorrow. So let's keep it focused session by session. And because of the higher demand that

we have in this update season we really need people to keep their comments brief and focused and need to avoid repetitive comments. I will repeat those ground rules at the break.

I think those are the basic points. Okay, let's then proceed with the presentations beginning with oncology.

DR. SOKOLOVSKY: Today I am bringing before you for the final time the Congressionally-mandated report on oncology services provided to Medicare beneficiaries. At this meeting I will present three draft recommendations for your consideration. An additional recommendation calling for the Secretary to conduct a study on acquisition costs for Part B drugs in 2006 has been eliminated because the IG already listed this study in their work plan.

I just want to briefly remind you of our mandate. This study is the first of two Congressionally-mandated reports on the effects of changes in Medicare payment rates for Part B drugs. Next year we will look at other specialties that provide many physician-administered drugs and have been affected by the payment changes. We will have an additional chance at that time to examine the workings of the new drug payment system.

I won't repeat all of the findings I presented to you in the last few months. The key finding, again, is that Medicare beneficiaries continue to have access to chemotherapy services, oncology practices continue to treat Medicare beneficiaries, and patterns of care remain largely the same. Neither beneficiaries nor physicians reported any change in quality of care.

However, going back to at least 2004, some practices were sending beneficiaries without supplemental insurance to hospital outpatient departments for chemotherapy administration. The Congressional mandate asks us about payment adequacy and I will comment on our ability to judge that later when I talk about the oncology demonstration projects.

One of the new payment systems for Part B drugs scheduled to begin in 2006 is the competitive acquisition program or CAP. CAP rules require that drugs be delivered to the facility in which they will be administered.

Oncologists in rural areas point out that they will not be able to participate in the CAP program because of this rule. Beneficiaries in rural areas tend to receive chemotherapy in satellite clinics. A group practice in a

central area provides chemotherapy once or twice a week at a small satellite clinic that's either owned by the physicians or in cooperation with a local hospital. Sometimes nurses have to mix the drugs at the main facility and take the drugs with them to the clinic because the clinic doesn't have the expensive equipment necessary to mix the drugs safely.

This leads to our first draft recommendation. The Secretary should allow an exception to the CAP delivery rules for satellite offices of rural providers.

Oncologists, again, in rural areas provide chemotherapy through these offices. If they can receive chemotherapy drugs in their main offices they will have the option of participating in the CAP program.

The spending implications are negligible, but it would help preserve access for beneficiaries in rural areas and allow rural providers to participate in the CAP program.

Last month we discussed the quality of life demonstration project initiated by CMS for 2005. CMS has developed a new demonstration project for 2006. These demonstration projects make it hard for MedPAC to evaluate the full effects of the MMA-mandated changes on the adequacy

of physician payments.

In the 2006 final rule CMS announced a new demonstration project. Practices must report on the reason for the patient visit, the patient's condition, and their use of clinical guidelines to treat the patient at that particular visit. Reporting will be through newly-established codes and payments would be tied to level 2 and above E&M visits by beneficiaries with one of 13 different cancers. Only hematologists and medical oncologists are eligible to participate. Payment will be $23 and beneficiaries will still be charged copayments. CMS estimates this project will cost $150 million.

That leads to draft recommendation two. The Secretary should use his demonstration authority to test innovations in the delivery and quality of health care. Demonstrations should not be used solely to increase payments.

Medicare demonstration projects are designed to test innovative strategies for improving delivery and quality of care for beneficiaries without increasing program spending. To test innovations, CMS must design projects according to accepted research standards. These standards

include a strategy for evaluation. Most researchers do not believe that the 2005 quality of life demonstration program can be evaluated and it is hard to see how the data generated can provide useful research findings.

The Congress again asked us to assess payment adequacy. Our analysis found that increased utilization and no sign of access problems, but we can't really tell if payment is adequate. MedPAC and the Congress's ability to assess the impact of payment changes for oncology drugs and drug administration services have been affected by the two oncology demonstration projects. These projects are not budget neutral. They are designed to increase payments to specific specialties.

In general, MedPAC finds that if the payment rates are not accurate CMS or the Congress should address the issue with Medicare payment policies. It should not make payment policy through the creation of demonstration projects.

This recommendation has no standing implications, but focusing programs' resources on projects designed to improve quality of care and care delivery should benefit beneficiaries and providers in the long run.

Erythroid growth factors are used to treat anemia, a very common side effect of chemotherapy. Erythropoietin has long been the drug that Medicare spends the most money on. Since a new product came on the market in 2002 use has increased very rapidly. Expenditures by oncologists for this product increased 33 percent from 2001 to 2002, and 51 percent from 2002 to 2003.

At the same time, safety questions have been raised about potential overuse and underuse of the products. ASCO has developed clinical guideline guidelines for its use and in 2004 the FDA changed label requirements to ensure safe use.

The ASCO quality project that we talked about last month found wide variation among practices in their adherence to clinical guidelines in the use of these growth factors. Guidelines set a target hemoglobin level for cancer patients and say the product should be withheld if the hemoglobin level exceeds that level.

Some local carriers have attempted to apply these guidelines, but they are hampered by lack of easy access to necessary clinical data. In the case of dialysis patients who also use these growth factors, providers must enter

hematocrit levels on the claim form. Last month CMS issued a national policy for the use of growth factor for ESRD patients based on these clinical guidelines.

So draft recommendation three is that the Secretary should require providers to enter patients' hemoglobin level on all claims for erythroid growth factor. The data should be used as part of Medicare's pay-for-performance initiative. Measuring appropriate use of erythroid growth factor meets many of the MedPAC criteria for quality measures. Accepted guidelines exist, the initial ASCO study showed variation in the use of the product and suggested room for improvement. Use of the growth sector is crosscutting, appropriate for many, although not all types of cancers, and practices can provide hemoglobin levels on Medicare claims with minimal additional burden.

There are no scoreable spending implications for this recommendation but there could be some program savings if carriers detect over or inappropriate use of the product and reject some claims. It could increase the quality of care for beneficiaries and, again, would create minimal additional provider burden.

That's the end of my presentation.

MR. SMITH: Joan, thank you. As usual, both the written material that we received and the presentation were clear and useful.

Glenn, I don't understand why the implications of the rationale that Joan recited and appear on page 44 of what we got in the mail, why they don't lead to a recommendation that says, the Secretary should cancel the 2006 demonstration because it doesn't --

This is obviously not a big deal in quantitative terms, but it is a case where without any argument that beneficiaries are better off, we're increasing beneficiaries copays. We're spending another $150 million of taxpayer money, and we argue, and I think convincingly and the discussion last month was even more convincing, that there's no value from this demonstration. It is designed to accomplish something else. That we should recommend, for the reasons that were clearly articulated, that the demonstration be canceled.

MR. HACKBARTH: Anybody want to react to that?

MS. HANSEN: I actually wasn't going to bring up the whole thing of canceling, per se, but the whole issue of

copays, bringing on the whole question of validity of the study to begin with. So one of the possible questions that would come out from this is the 2006 cancellation itself. But to have beneficiaries copay on something that has questionable value is a question I would bring up.

MR. HACKBARTH: Anybody else want to react to Dave's proposal?

From my perspective, Dave, I think it is a different thing to say this should have never been done in the first place. To say that in the midst of it, we're going to yank it away with the potential for disruption of the system, I think those are different propositions. I wish they hadn't done it in the first place but, nevertheless, I would be reticent about saying, it's out there and we're going to yank it out at this point. But I'm open to other comments.

MR. SMITH: If the disruption issue is a real one, Glenn -- I don't have a good way of assessing the potential for disruption, but I do know that we think we're not going to learn anything, and the Secretary is not going to learn anything, and that beneficiaries aren't going to be better off and that they're going to pay more.

DR. MILLER: Just a couple of other reactions. The estimated $150 million and it not being significant. One thing to frame in your mind is the difference between the amount of dollars that move out through drugs, which is a significant payment, and the amount of dollars that move out through administration. I think it is a question of how significant is this is.

The real frustration on the analytical side of things, and Joan I think is just being polite, is that we've been asked to evaluate the impact of these changes. Of course this was stuck into the middle of the changes so the ability to evaluate them -- and this is really just Glenn's point -- is we can't quite figure out whether this money is needed or not because they didn't let the payment changes go into effect. I think that's the rock we find ourselves on.

DR. REISCHAUER: I agree with Dave's point that this is a faux demonstration and inflicts costs on beneficiaries for which no benefit accrues. But by the time our report comes out this will be a month and-a-half down the road and I think the real issue is whether we should provide guidance for 2007, which is what this report is all about, and say something about ensuring that payments are

adequate so you don't have to phony them up with a demonstration, and be more explicit in the text about that, because we had the same feeling the last go round on this demonstration. So what happened? It was transformed into an equally invalid demonstration.

MR. HACKBARTH: The ultimate question for this study was would this quite significant change in how Medicare pays for drugs affect access to care, quality of care and as Mark said, the demonstration helped assure that we couldn't answer that question. So ultimately the question for 2007 is, we need a payment system that does assure access to quality care for oncology patients, but we still don't know what the right level is. At some point it seems like they're going to have to let the payment change go into effect without ameliorating its effect with demonstration dollars and monitor what happens.

I don't know how else you're going to answer the question.

DR. NELSON: Within the text, it makes the point that they've substantially changed the nature of the demo in 2006. So our evaluation was based on an earlier model. What they are proposing has implications of pay-for-

performance.

The other point is that the expenditures are going to go up to $200 million in 2005 and who knows what in 2006. But I think that for us to recommend pulling the plug when plans are in the works to substantially change it might be premature.

MR. HACKBARTH: Joan, could you just address a point that Alan made? Initially, our recommendation here was based on the first iteration of the demonstration. It has been modified. Is the second iteration -- I'm searching for a polite word -- more credible than the first?

DR. SOKOLOVSKY: I believe it is more credible, in the sense that there are three elements to it. One of the elements is to have an indication of the stage -- more than the stage, the condition of the patient. A second element is why did the patient go to the physician for this visit. The third element is the clinical guidelines, which it's not a yes or no question. It's a kind of okay, this patient came and I ordered a CAT scan for this patient with colon cancer at this particular stage now.

Then the question is, the clinical guidelines say you should have a CAT scan X number of times. Am I

following that guideline? If not, why? Is it because the guidelines are not acceptable? They aren't keeping up with the track. I don't believe in it. My patient is in a clinical trial.

I have some questions about the extent to which these will be coded correctly. I think they will take a lot of effort to code. But I think the first two elements of the issue of the condition of the patient and the purpose of the visit, when those are linked back to the A and B claims, will give us -- this is not demonstrating anything but it will give us far more information on the treatment of cancer patients in this country than anything that we have now.

What I was told by the people who set up this demonstration project is, their feeling is that they will be able to use these treatment patterns to develop a pay-for-performance system for oncologists that would be very difficult to do at the current state of knowledge.

MR. HACKBARTH: So that's also relevant for answering your initial question about whether we ought to recommend simply pulling the plug.

DR. KANE: I wanted to bring up a topic that we talked about last time and I think Joan did a nice job. You

did elaborate a bit on the people without Part B supplemental coverage, but I still feel we left that to some kind of long-term larger issue around Part B and the potential need for caps on copays. Whereas, this seems a little more to me, this particular population of people needing chemo who don't have Part B supplemental have been definitely put at greater risk by reducing the drug payments and the physicians' willingness to subsidize their copayments. And then, therefore, transferring them to hospital outpatient departments.

I would just be more comfortable if either we -- we say basically, beneficiary access hasn't changed but I'm not sure that is true, particularly for the Part B people without coverage because they are much greater financial obligations and potentially are not going for their care because of that.

I just feel we might want to make a recommendation that this issue needs to be studied in a little more urgent way than some kind of long-term study under general Part B copay limits because I feel these people are really making life or death decisions because they can't afford -- potentially, because they can't afford to meet the copay

requirements, and they're being put in a more expensive setting where the copays are more expensive. I feel like we just shouldn't say access is fine and hasn't changed because of this change in payment.

DR. MILLER: The only thing I would just look to qualify there, I think our site visit suggested that by and large what happens here is the person is moved to the hospital, and you're correct that the copayment liability becomes bigger, but since they aren't able to pay it what it turns into is a program cost by way of bad debt for the hospital. I don't know so much that -- we did see examples where people were saying, given this, I won't get treatment. But by and large, it was people moving to the hospital. I just want to be sure I have that right.

DR. KANE: You're looking at a very small sample size. Anybody saying, I won't get treatment is a pretty sad thought. And you're looking at very small sample sizes, so I don't think you can generalize and say, access is not compromised based on -- if anybody is saying, it's not affordable for me, you can be sure there are people --

MR. HACKBARTH: That's a broader point I don't think we can overemphasize, and that is that this whole

project by necessity, given time and resource availability, is based on site visits to five communities. So we're not talking about a comprehensive look at what's happening to all oncology patients and all locations. This particular finding, as I recall, was specific to two of the five communities where at least there was some report of -- in the case of patients without supplemental coverage being referred more frequently to hospital outpatient departments. Is that right, Joan?

DR. SOKOLOVSKY: I think the general access issue and the fact that there is an increasing number of beneficiaries receiving chemotherapy in physician offices is based on claims data. But when it comes to looking at beneficiaries without supplemental insurance, the claims data won't tell us that so it is based on these much more anecdotal site visits.

DR. WOLTER: My questions were really language questions in draft recommendation one and two. In draft recommendation one my question is, if you have an urban oncology program that's delivering care in a rural satellite, is that covered by this recommendation? Because of the way it's worded, rules for satellite offices of rural

providers. I assume the intention is that if someone is out in a rural area there would be coverage. So we might want to clarify that.

Then in draft recommendation two, I read the tenor of the chapter and the tenor of our discussion as, we would not want demonstrations to solely or partially increase payments. So I'm wondering if it would be better language just to say, demonstrations should not be used as a mechanism to increase payments. It's a minor point. I don't know if it really matters, but we probably wouldn't want them solely or partially to increase payments.

DR. CROSSON: I think I'd like to underscore what Nancy said. Last year, when we looked at benefit design in the MA program we called out for special attention to vulnerability of cancer patients on oncology medications. It seems to me that doing that in this setting might also be appropriate also. So if we could have stronger language in the text just calling out that issue.

MR. HACKBARTH: Any others?

We need to vote on these recommendations. This report is due at the beginning of January; is that right, Joan?

DR. SOKOLOVSKY: January 1.

MR. HACKBARTH: So this is our final look at this. So what we will do, in keeping with Nick's suggestion, is move rural in front of satellite in recommendation one so it would read, the Secretary should allow an exception to the CAP delivery rules for rural satellite offices of providers. Does that address your issue?

All opposed to recommendation one?

All in favor?

Abstentions?

Then in the draft recommendation two Nick was suggesting drop solely. So it should read, demonstrations should not be used to increase payments?

DR. MILLER: As a mechanism.

MR. HACKBARTH: As a mechanism to increase payments.

With that change in the wording, all opposed to recommendation two?

Is your hand up?

MR. SMITH: Yes, weakly.

MR. HACKBARTH: Okay, it will be noted in the back of the report as a no with an asterisk, I guess.

All in favor of recommendation two?

Abstentions?

Then draft recommendation three, I think the language on this one stands as is.

All opposed to number three?

All in favor?

Abstentions?

Okay, thank you, Joan. Good work on this project.

MR. SMITH: I should change my vote. I don't agree with the recommendation. I would prefer a better one, but that's no reason to vote no. I will vote yes.

MR. HACKBARTH: It will be so recorded.

Next is assessment of payment adequacy for hospitals. You may proceed when ready, gentlemen.

MR. ASHBY: Good morning. In this session we'll address payment adequacy for hospitals. We will be presenting draft update recommendations for both inpatient and outpatient services, although you will remember that we assess the adequacy of current payments for the hospital as a whole. Our session will conclude with a draft recommendation on an alternative to outpatient hold harmless payments.

I'd like to begin by briefly reviewing our findings from the November meeting. First, we have seen a net increase in the number of hospitals as well as an increase in hospital service capacity over the last several years. By the way, someone asked at the last meeting about the status of critical access hospital applications. The answer is that we now have 1,170 CAHs with just 20 to 30 applications still left in the pipeline.

Then we found that volume is increasing with especially strong growth on the outpatient side. That quality of care results are mixed with mortality and presses measures generally improving, but mixed outcomes for patient safety. And finally that access to capital is good.

Our first chart presents Medicare margins data through 2004. The overall Medicare margin dropped from minus 1.4 percent in 2003 to minus 3 percent in 2004. You'll notice that the drop was somewhat larger on the inpatient side than the outpatient side. This is partially because inpatient cost growth is higher, as Jeff will detail in a moment, but another major factor was a substantial drop in outlier payments for inpatient services. CMS implemented outlier payment reforms in 2003, but they overshot the mark,

going from substantially overpaying on outliers in 2003 to somewhat underpaying in 2004. So given that MMA provisions increasing both inpatient and outpatient payments kicked in in 2004, this drop in outlier payments, along with high cost growth, appears to explain most of the decline in margins.

Next we turn to our margin projection for 2006. I'll take a moment to stress first that some extensive modeling lies behind this one number and much of that modeling was done by Tim Greene and Julian Pettengill who are not up here and we appreciate their efforts.

The two-year projection accounts for a wide range of update factors and other policy changes that affect the distribution of payments, the level of payments, or both. That is for inpatient and outpatient services as well as hospital-based post-acute care and GME payments. In forecasting the increase in costs we use recent data on actual cost growth, going both from 2004 to 2005 and from 2005 to 2006.

On the payment side, we have to remember that payment increases come not only from updates and payment policy changes, which we've accommodated in our modeling, but also from changes in case mix. In forecasting payments

we made conservative estimates of the growth in case mix for both inpatient and outpatient payments, assuming smaller increases than actually occurred over the last three years.

As you see, our estimate is a margin of minus 2 percent for 2006. The 2006 projection is affected by policy changes both increasing and decreasing payments. Once again, as in the 2004 figure, one of the most critical factors for 2006 is outlier payments. Our modeling assumes that outlier payments will be restored to their target level, which CMS is attempting to do, and that factor is responsible for much of the projected improvement.

The gap in margins between urban and rural hospitals narrows in 2006 from about two percentage points to about one percentage point. This is largely due to MMA provisions targeted towards helping rural hospitals, and these are inpatient payment provisions.

Now Jeff will provide some more information on hospital cost growth.

DR. STENSLAND: The drop in margins that Jack just discussed has in part been driven by increasing inpatient costs. These costs have risen by roughly 6 percent in 2003 and in 2004. In contrast, outpatient costs have only grown

at roughly 1 percent per year. The natural question is, why is there a difference?

There's at least two reasons for this. First, we found physicians are ordering more services during every day a patient visits the outpatient department, a 2.8 percent increase in services per day from 2003 to 2004. These additional services per visit can result in lower costs per unit of service.

For example, assume a physician orders a pelvic CT and an abdominal CT on a single patient. Performing these two scans is expected to be less expensive than performing a pelvic CT on one patient and an abdominal CT on a second patient.

Additional services per patient creates economies of scale and reduces hospitals' average cost per service. In addition, hospitals face competition from ambulatory surgery centers and physician offices for outpatient services. This competition may put pressure on them to constrain their costs.

To arrive at the projected margins Jack discussed we need to estimate how fast hospital costs will grow over the next couple years. In 2004, the weighted average cost

growth for inpatient, outpatient and other hospital services was 4.5 percent. We have two pieces of information suggesting that we will see a similar rate of cost growth in 2005.

First, 580 hospitals surveyed by MedPAC and CMS reported that they experienced an average of 4 percent cost growth for the year ending June 30, 2005. In addition, an examination of recent financial reports from the three largest for-profit hospital chains shows that on average these hospitals had a 5 percent annual rate of cost growth through September 30 of this year.

Given these two pieces of information, the 4 percent cost growth and the 5 percent cost growth, we feel that an assumption that costs will continue to grow at a 4.5 percent rate in 2005 and 2006 is reasonable. Of course, this raises the question of how have hospitals been able to afford this continual rapid rate of cost growth.

As you remember from our presentation last year, we noted that private payers have been rapidly increasing their payment rates hospitals. This trend has continued into 2004. We also showed you last year that in periods when profits on privately-insured patients are high hospital

costs tend to rise faster than the market basket. In the prior slide we saw the private payer payment-to-cost ratios were high in the 2002 to 2004 time period, and in this slide we see that that the cost growth has been high during these same years. While the 2002 spike in cost growth may have been partially due to the nursing shortage, having four straight years of cost growth above the market basket appears to also be related to the lack of financial pressure from the private sector.

The survey I just mentioned, the survey we conducted this year of 580 hospitals, suggests that hospitals' revenue per discharge continues to grow in 2005, though there is an indication that the rate of growth in revenue per adjusted discharge has started to slow slightly. If we do see lower rates of revenue growth in hospitals we may eventually start to see lower rates of cost growth in these same hospitals.

Now Craig is going to talk about the interaction between hospital cost growth and hospitals' Medicare margins.

MR. LISK: We're next going to go on and report our findings from an analysis of hospitals with consistently

negative Medicare margins. If you recall, we included an analysis of hospitals with consistently negative margins in at last year's March report. The analysis I'm about to present to you this morning updates this analysis through 2004.

In this analysis we group hospitals into groups based on whether the hospital consistently had a negative or positive overall Medicare margin every year over a four-year period, and in this case from 2001 to 2004. We find that 34 percent of hospitals had consistently negative Medicare margins over this period and that 28 percent had consistently positive margins. Of note is the small share of hospitals, less than 3 percent not shown in the chart, that had both negative Medicare and negative total margins. That's total all-payer margins from all payers.

Our analysis today focuses on the cost-influencing factors that may contribute to poor or good financial performance for these two groups of hospitals. As you can see in the overhead, the consistently negative margin group had smaller average changes in Medicare and all-payer lengths of stay as compared with the positive margin group or the all hospital group. Similarly, occupancy rates were

lowest in the negative margin group and highest in the positive margin group. Higher occupancy rates should translate into lower unit costs as fixed costs are spread over more units of output.

We next move on to a measure of cost where we standardize for case mix and patient severity using APR-DRGs, outliers, wage index, teaching and disproportionate share. What we find is that negative Medicare margin hospitals have much higher standardized cost per case, about 7 percent higher than the median for all hospitals and 19 percent higher than the positive margin group. We also see that the negative margin group had a bigger average annual increase in cost per case from 2001 to 2004, one full percentage point higher than for the positive margin group.

We also find that total all-payer margins, which I don't have on this chart, are higher for the negative margin group than for the positive margin group. The negative margin group, therefore, may be under less financial pressure to reduce their costs which may partially explain their circumstances we're finding here.

Finally, I want to move on to compare these providers with their neighbors. Among the two negative

margin groups we see that their neighboring hospitals have stronger financial performance with higher occupancy rates and lower standardized costs per case.

Now Jack is going to come back and talk about hospital efficiency.

MR. ASHBY: This analysis assesses the effect of consistently high-cost hospitals on Medicare margins. We compared hospitals costliness based on the standardized cost-per-discharge measure that Craig described a moment ago. Then we identified a hospital as high cost in two ways: by its falling into the high quarter or its falling into the high third of all hospitals in both 2002 and 2004. We believe this dual test is important because it guards against the possibility that either a data problem or some special circumstance -- being hit by a hurricane would be a timely example -- explains a hospitals' high cost. Basically, lightning would have to strike twice for a hospital to inaccurately be identified as high cost.

Our table compares our two groups of consistently high-cost hospitals in the first two rows to all hospitals and then to consistently low-cost hospitals. In the first column we see that only 14 percent of hospitals remained in

the high quartile both years, and 21 percent remained in the high third both years. A substantial share of the high-cost hospitals in 2002, about 40 percent of them, managed to turn their performance around by 2004.

In the middle column we see that the persistently high cost groups actually had above average cost growth in the intervening years, so obviously they have not improved their situation.

And then in the far right column we see the tremendous difference in financial performance between the high and the low-cost groups from highly negative to highly positive.

We found that rural and non-teaching hostels were more likely than their counterparts to be in the high-cost groups, but much of this difference was driven by a single subset of hospitals, sole community hospitals, many of which are paid above PPS rates. Perhaps not surprisingly, we also found that government hospitals are over-represented and for-profit hostels are under-represented in the high-cost groups.

Focusing on the our forecast for 2006 we found that excluding just the 14 percent of hospitals with costs

consistently in the high quarter from the calculation raises the overall Medicare margin by more than a full percentage point from minus 2 to minus 0.7, to be exact. And excluding the 21 percent of hospitals that had consistently high costs as measured by being in the high third raises the margin by more than two percentage points to 0.1 percent on the positive side.

Turning to our update recommendations, we would first conclude that current payments are adequate in light of the continued need for cost containment, the need to limit Medicare's payment to covering costs of efficient hospitals, and our positive findings on the other payment adequacy factors.

The Commission's productivity factor is 0.9 percent, derived from the 10-year average of total factor productivity growth in the general economy. But balancing the importance of constraining costs with concern about the trend in Medicare margins, our draft recommendations call for updates of market basket minus half of expected productivity growth for both inpatient and outpatient payments. That's what shown on the next slide, and you can perhaps save a moment by not reading the full language here.

The Commission also represented market basket minus half of productivity last year, but our estimate of productivity growth in the general economy at that time was 0.8, resulting in a recommendation of market basket minus 0.4 in contrast to what is now quantified as market basket minus 0.45. The actual update for fiscal year 2006, the year that just started, actually was market basket even.

The implication of these draft recommendations for Medicare spending is a decrease relative to the current baseline and we expect no major implications for beneficiaries or providers.

So I now turn the presentation over to Dan.

DR. ZABINSKI: At the November meeting I discussed the issue that many rural hospitals receive what are called hold harmless payments under the outpatient PPS. Without these hold harmless payments the financial performance of rural hospitals under the outpatient PPS will be much worse than that of their urban counterparts. The issue facing the rural hospitals is that these hold harmless payments expire in a few weeks at the end of calendar year 2005.

I think a fair question right now is, why not

address this issue of the relatively poor performance of rural hospitals by simply making the hold harmless payments permanent policy? But the problems with the hold harmless payments is that they don't always efficiently target the appropriate hospitals.

For example, they can provide additional payments to hospitals that are already in some financial circumstances without the hold harmless payments. Therefore, the hold harmless payments are more costly to the Medicare program than is necessary to address the relatively poor performance of rural hospitals under the outpatient PPS.

Also in November I discussed two policies that would more efficiently address this issue. One issue involves the potential recalibration of the outpatient PPS so that payments more accurately match the costs of furnishing individual outpatient services.

The other policy addresses an issue of rural hospitals tending to have relatively high costs per outpatient service because they generally have lower service volumes than their urban counterparts and, therefore, the rural hospitals are in a lesser position to take advantage

of economies of scale.

I believe the best policy for addressing the high cost per outpatient service among the low volume hospitals is a low volume adjustment, in particular one where the lowest volume hospitals would receive the highest adjustment rates and then the adjustment rate would decline as hospital volume increases.

Also, a good low volume adjustment should have a distance requirement where a hospital would have to be at least a minimum distance from any other hospital furnishing outpatient services in order to receive a low volume adjustment. In November I suggested the idea of perhaps a 25-mile distance requirement. The basis for that is that the low volume adjustment for inpatient services has a 25-mile distance requirement.

Also at the November meeting some commissioners wondered whether other ambulatory providers, such as ambulato9ry surgical centers and rural health clinics, should be also considered when you think about whether a hospital meets a distance requirement. I think that's a valid issue and it's something that we do discuss in the briefing materials that the commissioners have.

However, the data that we have really aren't rich enough to tell us how well these other ambulatory providers substitute for the care provided in outpatient departments. So at the current time we really can't address this issue but it is something we should be attentive to into the future.

Now on a strongly related issue, in 2006 CMS intends to begin using a policy that will provide additional outpatient PPS payments to sole community hospitals that are located in rural areas. The purpose of this particular policy is similar to the low volume adjustment I've been discussing, that is to address the relatively poor performance under the outpatient PPS of rural hospitals.

I believe the low volume adjustment is a better policy than CMS's intended adjustment for the rural SCHs. First of all, because the adjustment for the rural SCHs is too broad and perhaps too imprecise, and that it provides additional payments to hospitals that are not necessarily vital to beneficiaries' access to outpatient care, and also provides additional payments to hospitals that are already in some financial condition, while at the same time it may not provide additional payments to hospitals that are facing

difficult financial circumstances.

In contrast, the low volume adjustment is more efficient in that it targets hospitals that are vital to beneficiaries' access to care as well as targeting low volume hospitals facing difficult financial circumstances.

In response to that I've drafted this recommendation that the Congress should enact a graduated low volume adjustment to the rates used in the outpatient PPS. This adjustment should apply only to hospitals that are more than 25 miles from another hospital offering outpatient services.

In the first sentence, the term graduated low volume adjustment means, at least from my perspective means that providing the highest adjustment to the lowest volume hospitals and then having the adjustment rate decline as hospital volume increases.

The spending implications of this policy is that it would have a very small budget effect. At this point I want to also add that this policy would have no effect on the payment for critical access hospitals because those hospitals are exempt from the outpatient PPS, and that was a point of confusion in November.

Then to close, the beneficiary implications is that it would help assure their access to hospital outpatient care.

Now I turn things over to the Commission for their discussion.

MR. HACKBARTH: I'm going to remind people again, just to make sure the message sinks in, that the draft recommendations, in this case, the draft recommendation on the update is a carryover from last year, what we recommended last year.

It might be helpful, Jack, or all of you in unison, to compare this year's situation and payment adequacy to last year. Are there material differences in either direction that we ought to be aware of?

MR. ASHBY: Yes. The two that I would cite are, first, that we have some evidence that the rate of cost growth has been coming down over what we had available to us last year. That includes a further potential step downward in 2005 from the survey that we co-sponsored with CMS.

And secondly, in looking at the adequacy of payments I can't overestimate how much difference the outliers make. It's kind of a side issue here but it makes

a lot of difference in looking at the adequacy of payments. We are now in a position to say fairly confidently that CMS is achieving some success in restoring outlier payments to what they should be. Much of that has already been accomplished for 2005. And the 2006 outlier threshold is lower and it indicates that it will happen. So that contributes to a better picture than we were looking at one year ago.

MR. HACKBARTH: Questions, comments?

MR. MULLER: A couple of questions and comments. On the face of it when we have a minus two projection on payments and say that the payments are adequate, is that largely based on our analysis of what you call the negative margin hospitals that if you can exclude the negative margin hospitals, or the consistently negative margin hospitals from the analysis then you're a little closer to break even? Is that how we're basing that?

MR. ASHBY: It's not excluding the negative margin, per se. It's excluding those with consistently high cost growth that one would label high-cost hospitals. In the absence of those hospitals, just in the calculation, we would have a margin that's basically in the range of

covering the costs of care.

MR. MULLER: So in that sense we're saying it's adequate for the hospitals that don't have negative margins.

DR. MILLER: I would state that a little bit differently. I would say, in responding to the question, there's factors other than the margins that are playing into this and we've reviewed those factors and some of those relatively positive. I guess in saying this, this is our attempt, and you could characterize it as crude, but our attempt to respond to, what is the efficient provider? That's something that Congress has pushed us and made as part of our mandate. So you can take issue with the analysis but the attempt is to say, is this a way to think about the efficient provider? I think it's in that context we're making the point.

MR. MULLER: We do show that quite a bit of the higher costs and the consistently negative margins are in the hospitals that have lower occupancy. That, obviously, intuitively makes sense, if you have lower occupancy and you spread fixed costs, you have higher costs and more negative margins. At the same time in the introductory comments we have more and more hospitals going to critical access.

So are we driving more and more hospitals towards securing or attempting to secure critical access status? Could you just comment a little bit on that, because the extent to which we have these -- again, I assume that the critical access hospitals are not in this sample, correct?

MR. ASHBY: Right.

MR. MULLER: These are just the PPS. So to the extent to which we have these lower occupancy hospitals with higher costs, which again makes intuitive sense, if you have lower occupancy you likely have higher costs and lower margins -- are these hospitals that are going to be able to qualify for critical access or these are the ones that really are outside the critical access rules in terms of location?

MR. ASHBY: Let me comment in two ways about that. Generally, we're saying that hospitals with low occupancy are in competitive situations. Craig's analysis showed that they're occupancy is lower than the hospitals in their markets, so they are essentially losing out in competition. As for areas where access to care might be a concern in some of these rural areas, then we do have 1,100 hospitals, almost 1,200 hospitals that are in the critical access

program so they're not subject to the constraints that we're talking about today. And in addition to that, we have a program, the sole community hospital program, that gives higher rates of payments as well for hospitals that are isolated. Actually not all of them are isolated, but the program is designed to provide higher rates for those that are isolated where access to care may be a concern.

So by balancing those two things --

MR. MULLER: So because of those rules on which ones get to be critical access, we're not as likely to take these third of hospitals, 30-some percent, that the negative margins and drive them over to critical access, right? Because there are rules they have to comply with to get into that.

MR. ASHBY: That's right.

DR. STENSLAND: We expect no more critical access hospitals, or almost no more critical access hospitals at the start of the year because they're getting rid of the state waivers, so critical access hospitals will have to be either the 35 or the 15 miles from another provider and there's almost no hospitals left that meet that criteria, of small size that might to convert to critical access.

MR. ASHBY: We've already reached the point where over half of rural hospitals are in the critical access program.

MR. MULLER: Let me just ask another factual point. In terms of our estimates for the margins for 2006, as you pointed out, there's a variety of policy changes and then we have some limits on hospital SNFs and we have the rehab rules, et cetera. You've taken all those into account? I heard Jack's qualifier on how you put the outlier provisions in because you're assuming that the outlier payments will be a target rather than where they are right now. But basically all those four or five other changes in terms of the expansion of the transfer rules, the rehab, the hospital SNFs, those are all --

MR. ASHBY: They have all been accounted for on the payment side of our projection.

MR. MULLER: It does surprise me that with a cost growth at the 5.8, the 5 percent over the last few years that the negative margin hasn't increased; that there isn't more of a negative margin, especially you have both the higher cost growth and you have these other factors, the ones you just mentioned. Maybe the outlier is so strong the

other way that it outweighs the -- because the acute transfer rules should probably have a minus one percentage point effect. I mean the expansion of the transfer DRGs. So it just surprises me, because in the past we have tended to underestimate what the margin will be in our forecast year because by and large, one, we underestimate the cost growth. We usually estimate it's going to be three and we always have this annual thing it turns out to be five or whatever, so the margins tend to be greater. So I'm just a little surprised that given the cost growth that we have here --

MR. ASHBY: But two comments though, and one is the outliers. I just can't overestimate how much difference that makes. Outliers is a $5 billion program. And the restoration of outlier payments to their target level actually has a greater positive impact than does the transfer policy in the other direction.

But the second comment I would make is that, in addition to a couple of policy changes that do have a downward impact on payments, we do have several payment policies going into this projection that increase payments. We have the expansion of disproportionate share payments.

We had the one-time appeals of geographic reclassification, for example, which is a $900 million, three-year program, and several other smaller ones.

DR. MILLER: If I could just say, Ralph, this same set of questions came up when I got this in front of me the first time too. How can we hit minus 3 and then at minus two? And the answer was the same, just so you know.

But I want to emphasize a point here on the outlier point because I drilled down on this little bit. We're assuming that it is restored and our best -- not our best guess. What we know at the moment is that has been brought up to 4.7 percent of payments.

MR. ASHBY: Right, two-thirds of it has already been restored.

DR. MILLER: I wanted to know how sure we could be that we thought they might come back up to 5 percent, and they're on a path back up. I thought I heard you guys say at one point in our discussions, they're at 4.7 percent.

MR. ASHBY: Right, for 2005. Plus the outlier threshold for 2006 is lower than the threshold for 2005. Certainly, that augurs for greater outlier payments.

MR. HACKBARTH: Jack, could I follow up on a

couple of Ralph's questions about how we project? My understanding of what you said was the protection from the actual cost data in 2004 forward to 2006 was based on the evidence we have on actual cost growth from the survey of hospitals and I'm blanking on the other source right now.

DR. STENSLAND: It's the publicly-traded hospitals.

MR. HACKBARTH: So it's the average of those two numbers, one was 4 percent and the other was 5 percent, so we rolled forward the 2004 data by 4.5 percent each year, correct?

MR. ASHBY: Right.

MR. HACKBARTH: Now in the past, as Ralph points out, we have tended do under-project the cost growth and therefore over-project on the margins. My recollection is in the past we used a different projection approach and at least, for like the last year we would tend to use market basket. Could you just describe the change in the projection rules?

MR. ASHBY: Last year and the year before we would assume a rate of cost growth based on the data again for the first of the two years and then assume market basket for the

second of the two years. This time we have assumed recent cost growth, as Glenn described, for both years, 2005 and 2006.

MR. HACKBARTH: You're right about the history of the projections. So that's being done a little bit differently to try to get more accurate on that.

The other piece of the projection is that in the 2006 projection we also take into account any new policies that are scheduled to go into effect in 2007. Were there any significant --

MR. ASHBY: One policy that we did take account of there was the one-time appeals of geographic reclassification. That is scheduled to go out in the middle of 2007. We accounted for it in that way. Whether Congress will extend the program, it's quite possible but we don't know.

MR. HACKBARTH: So you're saying the projection assumes that it's going to be eliminated in the middle of 2007 and people are going to fall back to their older, lower payment levels?

MR. ASHBY: Right. We actually estimated payments as if it were in effect for half the year and no in effect

for the second of the year. That was the most precise way that we could do it.

MR. HACKBARTH: That begs the question of whether in fact that's likely to happen.

MR. MULLER: This is probably more technical than we usually do, but when you see costs going up in our projection 4.5 and the update may be around three or so, just that's a big outlier effect, and maybe the geographic reclassification as well. You would assume the margin would get more negative. So just trying to follow exactly how we do that calculation. Those are more technical.

I'm sure, based on some of my colleagues, there's going to be a pay for performance discussion here so I will weigh in later on that one.

DR. WOLTER: A few points. I guess I think it's a stretch at best to say that payments are adequate if you exclude the one-third of the high-cost hospitals and end up with an overall margin of plus 0.2 percent. We've talked in the past about what overall margin is adequate and we, I guess probably rightly decided, we wouldn't pick one.

MR. ASHBY: Let me just clarify though, it's excluding the one-fifth of hospitals that had costs

consistently in the high third. So it was really only one-fifth of the hospitals.

DR. WOLTER: But regardless, I think we are on a little bit shakier ground this year than maybe in past years on that particular statement, just as a personal point of view.

Then I guess for the record I do have a dissenting point of view on the theory that's being proposed in the chapter that the private sector leverage is the cause of the increasing costs. What I don't see in the chapter is enough balance around some of the real issues that are going on in terms of investment in technology, costs of HIPAA, privacy, security measures, the labor cost issues that have really, I think, increased in recent years around nursing, physician and other, pharmacy, other highly technical positions, the cost of liability insurance, particularly as more physicians are being employed.

Some of those factors are the cause of the increased cost, not just the fact that there's private sector leverage. It would be nice to have a little balance, at least in the text around that. I don't think it's as balanced as it might be.

Also, I don't think all markets are the same in this country in terms of the potential for leverage into the private sector. I certainly think there are a number of markets where that particular leverage is more difficult and cost shifting is certainly more difficult. I think the argument that relative underpayment in the Medicare system might in and of itself be a cause of trying to leverage the private sector has some merit.

Having said that, I certainly agree that when you have leverage in the private sector it allows you to look at your costs differently. So I'm not disagreeing with it. I think the story is more complicated than we have presented it.

Then I think that there are some other things that do concern me a little bit. I remain concerned that as we continue to not look more carefully at the negative outpatient margins that will have downstream effects in terms of where hospitals make their investment, and their investments will tend to concentrate on those highly profitable inpatient services. We may find ourselves with a problem in future years if we don't try to address, do we have an issue with negative 10 percent outpatient margins or

are we so sure on cost accounting issues that we can continue to ignore that? I worry about it.

I'm a bit worried about the technology question. We used to have the 0.5 percent adjustment for technology. The current mechanisms to address technology in the payment system are fairly specific to individual new technologies and really don't cover some of the larger system technology needs that are currently on the table.

So those are some of my concerns on the inpatient and outpatient update.

I do think sustainability of the Medicare program is a good reason to be careful about how big the update is. We have a serious budget problem in this country so to me that's fair game.

Then lastly, on the rural outpatient issue, I am 100 percent philosophically on board with a low volume adjuster probably being a better approach than certainly permanent support. However, I'm a little bit worried about how much we are reducing that support in this near-term time frame. If I'm remembering what the chapter said right, the current proposal would reduce to about 17 percent of rural hospitals that would receive some kind of support through

the low volume adjuster. Is that what I'm remembering?

The concern I have is if you look back at the history of the critical access program it actually was the outpatient sector that was causing the margin problems in those small, rural hospitals. I think the fact that it took quite a while to think about that issue led to a movement in the industry to create that cost-based reimbursement system. Had we been perhaps more aggressive with low volume adjustment early on in that group of hospitals we might not have a critical access program today. I don't know where every one is but there's a group of institutions now that call themselves tweeners that are actively pushing Congress to increase up to 50 beds the hospitals that would have cost-based reimbursement available to them.

So I'm just a little bit worried if we go too far in terms of the support to these remaining PPS rural hospitals in terms of reducing it, we may see ourselves again with a movement to push cost-based reimbursement further than it is today. So it's just an angst I have about the recommendation.

MR. HACKBARTH: Could I ask about that? You said that you agreed conceptually that we ought to target the

assistance to low volume. Where would you liberalize it if you were going to liberalize the proposal, reduce the mileage so more hospitals qualify?

DR. WOLTER: I think that actually has good rationale. I'm not sure how sure we are that 25 miles is a good proxy for access because, as we've discussed in the past, in some markets both of those institutions, even though they're low occupancy, may have good reason to exist. So going to 15 miles might be one thought. Creating a transition over several years to better understand what we have going on might be another possibility.

You look at those rural margins of the remaining PPS hospitals and they do remain still more negative than the urban margins. If we take away the support for the outpatient side and those margins get worse I'm just afraid that a number of different reactions will occur, including this --

MR. HACKBARTH: Could we talk for just a second about the 25 miles? Obviously one reference point there is that's the mileage used for the inpatient low volume adjustment.

On the other hand, there are a bit different

dynamics when you're talking about outpatient services than inpatient and I'm not sure which way they cut. On the one hand you're more likely to make the trip for outpatient services more frequently, in which case any given distance might become more burdensome. On the other hand, for inpatient it's more likely to be something that you've got to get their fast.

Have you thought about the 25 miles and whether or not it would be different for outpatient? What did you conclude there? Obviously you concluded it shouldn't, but what was the thought process?

DR. ZABINSKI: Actually, my initial thoughts on this were actually back to the initial recommendation we made for the inpatient, which was a few years ago, which was 15 miles and the first simulations I ran looking at how many hospitals qualify for a low volume adjustment, what sort of budget impacts, et cetera, were using a 15-mile requirement. Just as a back of an envelope estimate, you multiply everything by a factor of three if you go down to a 15-mile requirement. By that I mean, the fraction of rural hospitals that would qualify goes from 14 percent up to 41 percent. The budget impact also goes up by a factor of

about three.

But then after a little more thought on how the legislative process worked out, that the Congress arrived at a 25-mile requirement, and that's why I ultimately chose to present that particular number.

DR. MILLER: I don't want to put too much science on this. You can discuss this, so we started with the inpatient reference point.

MS. DePARLE: First, I agreed with what Nick had to say about outpatient margins and the need to be able to more carefully consider what's going on there and have better analysis of that. I think he's raised this for at least the last two years, and I know it's difficult -- we probably just don't have the data -- but I think he's right, that we need to understand better what's going on there.

Secondly, on the section in the written document about access to capital, I made a comment at the last meeting about a report that had been issued by one of the three major rating agencies saying that they were going to take into consideration -- it was a pretty strong report actually -- whether or not a hospital had clinical information systems and if they did not it would be

something that they would consider for negative ratings. I did find that report and sent it to Mark.

Also, I mentioned that I had understood that the agencies are now looking as well at compliance with Sarbanes/Oxley or something like it and increased requirements around governance and financial reporting among non-profit hospitals. I think that's something that, for lots of reasons including perhaps the first that Nick raised and I raised about data, that we would support better governance, more transparency, all those things, but that will have costs.

I did find the three major rating agencies in the last literally month, one last week, have all issued reports on this. Not yet saying it will be required, you will be negatively rated or downgraded, but all three saying, we're going to start looking at this more carefully, and one saying that it may positively influence a hospital's rating if they follow the Sarbanes/Oxley-like requirements. So I believe that should either go in this chapter under the access to capital as something that we're monitoring, or under costs, because it belongs in one of those two places. The costs, I think, are going to be increasing.

Finally, I was curious. We don't say anything in here, and maybe there was a discussion I missed earlier about this, but we don't really say anything about what our view is of the -- it's not an experiment, but the requirement that Congress imposed for hospitals to voluntarily report data in order to receive the full market basket, which I guess goes through 2007. What has that shown us so far? What do the data show? And the premier demo, I guess we don't really talk about that either. What is MedPAC's view of that?

I guess that leads me to the subject of, have you considered or should we be considering some more robust pay for performance recommendation here? Maybe that's what Ralph was alluding to.

MR. HACKBARTH: Could we just touch on this outpatient cost allocation issue? Nick has raised that several years. I think it's important that we not ignore it. So, Jack, do you want to just talk about what we've done to try to --

MR. ASHBY: Let me point out two things. First of all it would be stating the obvious to say this is a continual source of frustration that we have gotten to the

bottom of this issue. We have plans for another go at it after the holidays, and a different analytical technique, to try to answer the question about how accurate the relative margins are. That's the best answer I can give at the moment.

But I would also point out that the inpatient and outpatient margins, as they are currently measured, do show that the gap between the inpatient and outpatient margins has narrowed by four percentage points in just the last two years. There's a lot of policy changes that affect that, but mostly that's capturing the difference in rate of cost growth that Jeff put up. We have low outpatient cost growth and so --

DR. WOLTER: Isn't that because the decline in the inpatient is faster than the decline in the outpatient margin, in essence? That's what's narrowing the gap.

MR. ASHBY: It does reflect our pesky outlier issue, which for 2004 brings inpatient payments down. But it also reflects the difference in cost growth. We do have two years of very low outpatient cost growth and that is going to improve outpatient financial performance however we might be measuring it.

MR. LISK: I want to add something though. We also see large volume increases on the outpatient side. That's again to remind you what Jeff had, is that's one of the reasons why we see the lower cost growth on the outpatient. So it's the same type of situation we have with physicians where we see volume growth could be a reason for some lower cost growth.

MR. HACKBARTH: So as I think you know, Nick, it's not that any of us think that the issue is unimportant that you're raising, do we have the cost allocations right? There has been a reluctance to assume that the reported allocations on the cost reports are accurate. We've tried at least a couple different approaches to get to a better number, thus far unsuccessfully, but we're continuing to try to find a way to address your issue. It certainly is a legitimate and important one.

DR. STOWERS: I also had a question on the rural payments there. Nick made many of the same points that I was going to make so I won't go back over all of those. I would totally agree that we're maybe making a step in the right direction with the low volume adjustment. It would be great to be in a world where we didn't need cost

reimbursement at all, if we could correct for all of the things that affected the difference in PPS for the rural hospitals.

But that brings me around to, the reason for the outpatient hold harmless was for myriad different reasons, not just low volume. I think it was our 2003 report that listed a bunch of those. I'm just kind of curious, when we get down to maybe that the budget impact is a small one, is the proposed low volume adjustment that you're talking adjusting for all of these factors that brought about the hold harmless payment? Or are we looking at an increase in payment to rural hospitals? Because we definitely made the statement, outpatient financial performance is much worse without the hold harmless. Are we coming out on these rural hospitals to the positive, to the negative with this?

DR. MILLER: Let me try and address at least --

DR. STOWERS: I'm trying to get a feel for the overall impact here on the --

DR. MILLER: Let me say at least a couple things. I think, to take your question apart into pieces, it definitively does not address all things that might have been addressed by the hold harmless. The hold harmless

basically says, if you're going to realize any negative impact it won't be allowed to happen. So it doesn't address all of those factors.

I think what our analysis said is, what would legitimately be something that a prospective payment system would want to correct for in a low performance hospital, and it was the need for access and the fact that they had low volume because they were so far removed from other -- they were in a remote area.

It is a small budget impact. In our typology which we've used in proceeding years and we haven't talked about a lot here, it's less than $50 million in one year, I believe. But the point I wanted to make, in case this was part of your question and I wasn't sure it was, we're seeing this as an increase. This is not a budget neutral adjustment. This would be new money that would go into the system.

DR. STOWERS: That was my question. So in essence they're gaining a little.

DR. MILLER: That's correct.

DR. STOWERS: But it would be a redistribution between the --

DR. MILLER: It's new dollars.

DR. STOWERS: But I meant in total, the hold harmless money would be better distributed to those of low volume versus those --

DR. MILLER: But just to be clear, I don't think it's dollar for dollar. The hold harmless money ends at the end of this year. So this is saying, if that's going to be gone, this is the policy we recommend and it is new dollars. But it's not dollar for dollar on the hold harmless.

MR. HACKBARTH: What are the relative magnitudes?

DR. ZABINSKI: With the 25-mile distance requirement it's one-tenth as large as the hold harmless. As I said, if you go with a smaller distance requirement, such as 15, with the 15-mile requirement it would be one-third as large as the hold harmless perhaps.

DR. STOWERS: Does that mean there's a loss of 90 percent or of two-thirds of total dollars into these rural hospitals?

MR. HACKBARTH: From this particular adjustment. He's saying with the hold harmless -- what's the magnitude?

DR. ZABINSKI: It's about $150 million a year.

MR. HACKBARTH: $150 million, If you have a 25-

mile limit it goes down to like $15 million in new dollars?

DR. ZABINSKI: Right.

MR. HACKBARTH: If you go to a 15-mile limit it would go up to about $45 million in new dollars.

DR. STOWERS: I guess my concern here is the timeliness of all of this. If we're talking that low of dollars, but on one hand we're saying that financial performance would be much worse for this particular set of hospitals and this thing is expiring the end of 2005, I'm not so sure -- and I'm not trying to perpetuate a bad system but I'm not so sure we shouldn't be saying we should extend the hold harmless until some kind of low volume or something can be put in, because this low volume can't be put in overnight. And even at that it looks like it's going to allow for a relatively small part of what's going to be lost in the hold harmless. So I'm trying to get a grasp on how this timing is going to work for 2006 and 2007.

DR. ZABINSKI: We did recommend last year extending the hold harmless for one year through calendar year 2006 with the intent purpose of examining this issue and coming up with a policy that more directly addressed the relevant issues affecting the issues facing the rural

hospitals. So the intent purpose of this particular policy, the low volume adjustment, would be like 2007.

DR. STOWERS: I'm not totally against that. I'm just wondering why would not be recommending -- knowing the negative impact that's hanging there -- why we wouldn't be recommending the continuation of the hold harmless until another system can be put in place.

DR. ZABINSKI: Exactly.

DR. STOWERS: I'm not sure we're saying that.

DR. MILLER: I think we have said that and the Senate Finance bill does have a continuation. So we've made that recommendation, at least the Senate Finance side --

DR. STOWERS: We made it 2006.

MR. HACKBARTH: But that ought to be enough time to do the low volume for 2007. We ought to be able to do it within calendar year 2006.

The real problem is that as yet our recommendation of continuing it through 2006 has not been enacted because there's not been a Medicare bill passed. But it's not because we didn't recommend it. We have recommended it. It just hasn't happened yet.

DR. REISCHAUER: A couple of questions. I want to

ask Jack about outliers. The pot went to around 3 percent.

MR. ASHBY: 3.5.

DR. REISCHAUER: And it's going to be brought back up to where it should be, around five.

MR. ASHBY: 5.1.

DR. REISCHAUER: That clearly will affect margins in the aggregate.

But the question I have is, what about the distribution of this? We know that all hospitals don't avail themselves of the outlier provision equally. Certain types do. Do we know whether those that are likely to receive the greatest amount of this additional two percentage points will be those that already have positive margins? Or will they be largely those that don't have positive margins? Of course this is money that comes out of the overall payment for everybody else.

MR. ASHBY: I think the most important point is that once we get to the point where it is operating as it is supposed to, and that's what we're heading towards, then the money will go to those hospitals that are incurring the additional costs of treating outliers. That's the real point.

As to whether those hospitals that are incurring the costs are the ones with the high margins, many of them are, because they are teaching hospitals that have a little bit higher margins than others because of the IME payments. But that's really an IME payment issue and not in outlier issue.

DR. REISCHAUER: I confess to having known a little bit about the answer before I asked the question.

MR. ASHBY: I think it will go to the appropriate hospitals in terms of the costs incurred, as the system is designed to do.

DR. REISCHAUER: But if we get a distribution of numbers of hospitals that have negative margins that might not change very much.

MR. ASHBY: Not very much, I would think, but we haven't done that specific analysis.

DR. MILLER: The IME point is part of the point, but also the specialty hospital work suggested that there was possibly some refining to be the outlier policy as well. So I would say your question is a good one on at least a couple of fronts.

DR. REISCHAUER: Dan, when Nick said 17 percent of

the rural hospitals would be affected by this and you were looking perplexed and looking at your notes, I don't remember reading any number like that. Maybe there was one there and I just missed it.

DR. ZABINSKI: It's 14 percent.

DR. REISCHAUER: But I was just thinking, if we think of all rural hospitals, how many are left when you take out sole community hospitals, take out critical access hospitals and you take out the ones you're going to give a low volume to for outpatient or who already get it for inpatient, I'm wondering if there's anybody left in the room here. And the Medicare dependent ones.

MR. LISK: If you talk rural hospitals that don't get special treatment, there's probably about 450 left. So if you think of the sole community hospitals, the Medicare dependent, and the rural referral centers you're left with about 450 rural hospitals that are just plain, vanilla rural hospitals that don't qualify for any of these special programs. We've reached a turning point where there are now more critical access hospitals than there are rural hospitals including the ones with these special treatments.

DR. REISCHAUER: Thank you. A final thing that's

really a comment and goes to Nick's concern about outpatient services and perpetually large negative margins that we have for this group of services. I'm just confused because we have very low margins, negative margins. They're getting a little better but they're still quite low. So they are incurring a loss here. And yet the volume of services and their activity in this area is such that they are increasing the business.

It's a little like, I lose on every sale but I'm going to make it up in volume. You have to ask yourself, what's going on here, because just from the numbers you've given and the increase in volume you have to think that the aggregate loss is rising each year on this business, if these numbers are right.

MR. LISK: The other thing is they're covering --

DR. REISCHAUER: Between marginal an average cost, which is --

MR. LISK: They're covering their variable costs, is the issue. The more patients they get they're likely covering their variable costs. That may be one reason why the outpatient margin is actually improving slightly even though it's still substantially negative.

MR. HACKBARTH: Technology changes, practice changes, and just things that are generally moving from inpatient to outpatient, presumably that has an effect on this also.

DR. REISCHAUER: I wonder, given the change in the margin over the last year versus the growth of the volume, whether that's actually true, that the variable cost is being covered.

DR. WOLTER: Just real quickly on this question. One point I'd make is I honestly think most of us don't know what our margins are in the outpatient arena because the system is pretty new and the way the bundling has occurred makes it harder to do some of that accounting. So I think we're a little bit murky on it, just as our commission is.

MR. SMITH: Bob anticipated two of the things I wanted to mention. I did want to come back to Nancy-Ann's question, which didn't get picked up, is as we look at a similar set of problems to other provider sectors, as we look at what at first glance suggests that we're trying to increase volume, service volume is increasing in order to deal with either low or reduced margins so that -- and you look at where service growth is increasing, in the mailing

material. It is increasing in the same places that we've expressed some concern about with respect to physicians, a lot of increase in imaging services.

It seems to me we ought to ask yourselves whether or not it is time to begin a process of tying the update, whatever the update is, forget for a moment what we think it should be, but tying a substantial portion of the update to a set of more robust pay for performance measures. We've talked about that. We don't reach it in this chapter although there are the same kind of warning signals, it seems to me, that ought to make us pay some attention to that.

Second, let me go where I thought Bob was going to go and he chickened out. Isn't the right response to low volume, high volume? And how we get high volume if we insulate those who would it be performing better with a low volume adjustment?

I don't know where those 400 hospitals are, but with something approaching 1,200 critical access hospitals, with Medicare dependent hospitals, with sole community hospitals, it's hard for me to imagine that all 400 of those are for some other reason critical service providers in an

otherwise isolated geographic region. The report ought to suggest, it seems to me, that we have an opportunity that we ought not to insulate the system or the providers from, to try to address the question of negative margins being driven by low volume by more consolidation.

I don't want to propose a recommendation, but at least it to note that we do have a lot of other insurance systems around to protect access in isolated communities and some assessment of whether or not we need another one, and rather ought to turn this problem on its head and seek to increase volume and the economies of scale that come with it, is something we ought to ask ourselves about.

DR. REISCHAUER: I think it's a trade-off between efficiency and access, and that's what the mileage is supposed to do.

MR. HACKBARTH: To strike that balance.

DR. WOLTER: I think my thesis is that some number of those remaining 450 hospitals probably play an important role in health care delivery. I'd love to have you come to Montana and see what kind of population density gets served by some of these hospitals. But I think you're asking a very good question and maybe there's a way to look at that

and look more specifically at these locations, and how they exist relative to other services that are available within a reasonable either time frame or mileage frame. It's a very good question.

My angst is, I don't know the answer to it and I'm worried that some of them are important.

MR. SMITH: I wasn't suggesting that we prematurely reach an answer. I don't know what the answer is either. I do think if we've got persistently low volume institutions with persistently low all-payer and Medicare payer margins, and for one reason or another they don't fall into a pretty elaborate network now of safeguards against access, that we ought not to create another safeguard before we try to wrestle with the question do we have a better way of understanding when these are crucial? And does a general low volume adjuster address that? I'm skeptical.

MR. HACKBARTH: The question I thought you were going to raise before you chickened out was the much bigger question of the overall utilization of capacity in the inpatient/outpatient business across the country. I don't know what the average occupancy rate is right now.

MR. ASHBY: It's in the high 50s.

MR. HACKBARTH: So to put it in the harshest terms, why should we be trying to assure high profitability or any level of profitability in an industry where we've got 50-some percent occupancy?

MR. MULLER: Those are really misleading numbers. People don't staff 45 percent beds that are empty. I don't want to get into a debate over how you do your calculation, but there's not 45 percent staffed beds that are sitting empty.

MR. HACKBARTH: I'm sure you're right.

MR. MULLER: But a practical average, the practical limit is around 80 anyway because most hospitals tend to empty one-third or one-fourth on weekends anyway. Since they take these numbers over seven days, 80 percent is like 100 percent for the other five days. But still obviously, as the numbers show, a higher occupancy/lower average cost, et cetera. But it's not 45 empty.

MR. HACKBARTH: I accept that and your points are valid. I think the basic issue still remains though, we've got a payment system in Medicare and among many private payers that does not force the system to higher levels of efficiency by directing patients to the highest performing

institutions. We pay higher costs in Medicare and as a society for that method of payment.

MS. DePARLE: I meant to raise this earlier and maybe it's not fair game because it a little bit gets into the subject of other than Medicare margins. But since we have a section in the written document about the extent to which cost growth follows changes in the profitability of private sector patients it seems to suggest that they've become more profitable in recent years.

It seems to me we should be clear about the extent to which bad debt affects this. At least in the proprietary or for-profit hospital sector -- I don't know the data as well with the not-for-profit sector -- but bad debt is an increasing problem and an issue of real concern to hospitals who are experiencing the logical impacts of high unemployment rates, people losing insurance, everything that we have seen from the reporting that's been done about changes in the commercial insurance market is coming to rest at the doorstep of hospitals.

We have one little comment about uncompensated care burdens can also place financial pressure on hospitals. But we sort of characterize it as a positive thing because

we say it can put pressure on them to constrain costs. That's true, it can, but it's also an increasing source of concern. Again, perhaps we don't think it's something we should consider because Medicare does have some payments for bad debt that would help with at least Medicare patients, but it seems to me that it's a bit of a canary in a coal mine, at least what I'm seeing.

MR. ASHBY: Let me just say this. We don't have a reliable measure of uncompensated care so it's a little bit hard to get a grip on. But as hospitals reported, as they calculated, they choose to calculate and report it, the available data suggest that uncompensated care has only gone up just a smidgen, even through mid-2005, the results that we have from our own survey we sponsor with CMS. Also there's some shifting from bad debt to charity care. Hospitals are now calling it charity care in response to the pressures that they're under rather than bad debts.

MS. DePARLE: That surprises me because the data I've seen would suggest -- a smidgen is several percentage points and that can be, what I've seen at least in the for-profit sector, quite a lot.

MR. ASHBY: There's no national data source that

would support that several percentage point conclusion.

MS. DePARLE: That's interesting.

DR. MILLER: Also to your other comment. If that chapter conveys that it's a good thing because it puts cost pressures on them, we'll definitely redraft it to fix that. I'm sure that's not the point that we were trying to convey there.

But I also wanted to say, the uncompensated care data that we have is very questionable and we're not certain about it, but we're not seeing that kind of point. But we're not trying to make that point and we can make the uncompensated care issue more clear in the chapter. We certainly weren't trying to convey that.

MR. HACKBARTH: Let's move ahead and go on to our next topic. Thank you all.

Next we're going to talk about the wage index. This is an informational discussion. It will not include any recommendations.

MR. GLASS: Good morning. We're going to take a break now from the update discussions and talk about the wage index for a bit. This is work we introduced in September. Today we'll discuss some of the issues we'll

dealing with in that work.

We'll look at four wage index issues today. First is the wage index boundary between MSAs and rural areas. This is the so-called wage index cliff problem. Remember that in this system a wage index is calculated for each MSA and then a single wage index for the non-MSA or rural area of each state is calculated, and it's the boundary between those two, the rural area and the MSA that we're going to talk about. We're also going to talk about using the hospital wage index in other sector and whether or not doing so creates some problems. Jeff is then going to talk about variation both over time and within an MSA in the wage index.

So the first question, the MSA cliff, this could look like a snow total accumulation expected for the Washington, D.C. area, higher in the northwest suburbs, lower in Virginia. But in fact, this is the 2006 hospital wage index. You can see that it's highest in two counties in Maryland there, Montgomery and Frederick Counties. That's a dark red. Then the rest of the MSA is in pink there. That's the second-highest. Then it goes white, and then blue is the lowest levels down in the rural Virginia

areas. The MSA is actually made into two divisions for wage index purposes and that's why you have it higher in two of the counties in the MSA.

So the subject is where you have the pink bordering the dark blue there. Where you have that situation, the dark blue is getting about one-third less than the pink areas. That's what the MSA cliff is all about.

They've tried several ways of trying to smooth out the cliff and first is the out-commuting approach. That gives counties an add-on if the hospital workers in that county are employed in neighboring higher wage counties. There's two issues with this. One is linked to wage index values. Those are the same for all counties in an MSA. So whether you're county borders a central county or an outlying county of an MSA, the same adjustment is made.

The other is that it's computed once every three years and that doesn't reflect changes -- wage data is volatile -- and it can lead to some anonymous results such as Montgomery County in the previous slide actually gets a wage index add-on even though it's already the highest one in the area. That's because when the add-on was computed it

was lower than the other ones in the area. So you get some odd results from this one.

We can see what it looks like. Montgomery County gets a little better and Culpepper County, which is down there in the lower left part of the slide, turns white instead of blue. So it does fix some of the problems in the sense of smoothing out that boundary by raising some places, but it can also create some other anomalous things like the Montgomery County addition. The cliff now becomes -- to Culpepper it would be about 15 percent instead of 30 percent now.

There are a lot of other approaches that have been taken to solve problems in the wage index. Reclassification, for example, has been used. That results now in most North Dakota hospitals are reclassified to Fargo, including one that's over 400 miles away, which would be kind of a broad definition of a labor market area.

Also North Dakota, over 30 hospitals are now CAHs, and that's about three times as many as there are IPPS hospitals, I believe. So those CAHs no longer figure into the wage index at all. Their data is no longer counted. So that's another issue with some of this.

You also get results like New Hampshire rural floor being higher than the Boston wage index, which would seem unusual. And that some hospitals, to add insult to injury, get an addition for out-commuting as well, in some hospitals in New Hampshire.

So when you take all these things together, about one-third of hospitals' wage indexes end up being altered with one or another of these provisions. The limitations of the current wage index system have been recognized but the cure has so far, the ones that are in place, may have some major side effects.

The other issue I want to talk about was using the hospital wage index in other sectors. As you can see, most other PPSs now use the so-called pre-reclassification hospital wage index. That's the one before anything is altered, before floors, before reclassification. That's the first picture we saw in the series.

Post-reclassification is what the hospital actually gets, and there can be a substantial difference between pre-reclassification and post-reclassification wage indexes. The difference can be as high as 40 percent. For over 100 hospitals, the post-reclassification wage index is

over 20 percent higher than for the pre-reclassification wage index.

Now what that means is that a SNF and a hospital in the same town can have different wage indexes but compete for the same workers. So one could then construe that providers in other sectors getting the pre-reclassification competing with hospitals for labor could be, theoretically, at a disadvantage. But that would assume that all other payments were accurate in all their ways, financial circumstance were the same, which are fairly large assumptions. But it does raise some question about this system.

Now Jeff is going to talk about variation in the wage index system.

DR. STENSLAND: One of the things we wanted to look at was how stable is the wage index over time. Basically, does a hospital have its wage index bouncing up one year and then bouncing down the next year? We're somewhat concerned about that. As this chart shows, most hospital had less than a 2-percent shift in their wage index from 2005 to 2006. However, about 7 percent saw their wage index decline by 4 percent or more.

Now we looked at these hospitals with a decline in their wage index and saw that over the prior five years on average they had a 5 percent increase in their wage index. Hence, what this large drop was doing was really just bringing them back to where they were five years earlier.

Now if we look at the other side of the chart and look at the winners we see that roughly 8 percent saw their wage index increase by more than 4 percent. In contrast to the declines in wage index, many of the shifts upward in wages are not offsetting earlier year losses. These often represent net gains to the wage index, in some cases from hospitals being reclassified into a higher wage index area.

Due to these reclassifications, we see that the average wage index over time is increasing slightly. Historically, CMS has paid for the cost of increasing wage indexes with a budget neutrality adjustment to all hospitals' base payment rates. However, the MMA has not followed this precedent. The new wage adjustment enacted as part of the MMA, that's the 508 adjustment and the out-commuting adjustment, those are both not budget neutral. So those two new adjustments add new money into the system.

To summarize, we have some large declines that we

occasionally see in the hospital wage index, but this is usually due to some temporary noise in the data. We have some large increases that we sometimes see due to reclassifications and these are often permanent, and in some cases these reclassifications can add new money into the system.

Now in addition to examining one-time increases or one-time decreases in the wage index, we also wanted to examine how often hospitals experience persist large increases or persistent large decreases in their wage index. We found that only 18 hospitals experienced more than a 2-percent increase in their wage index for three straight years. These hospitals often benefitted from reclassification in one of those years.

We also found 16 hospitals that experienced more than a 2-percent decline in their wage index for three straight years. These declines are often partially explained by the new MSA definitions that went into effect in 2005. What these new MSA definitions did is, in some cases, they moved higher wage hospitals out of a market, causing a decline in the wage index for hospitals that remained in that market.

The lesson I get from this analysis is that the long-term trends in a region's relative wages tend to move at a very slow pace. We do not see year after year large monotonic increases or larger monotonic decreases in hospital wages.

Now David earlier had talked about a rural-urban cliff. I'm going to talk a little bit about wage variation within an MSA. As an example, we looked at the Washington, D.C. MSA which is quite large, the picture that David had up earlier. This slide shows the variation in nursing wages within the Washington, D.C. MSA. In the center of the market, which is the actual city of D.C. and the adjoining Fairfax and Arlington Counties, the average RN earned $24 per hour in 2000. In the second ring of counties, which is roughly an hour drive outside of the center of the city, nurses earned an average of $22 per hour. In the outer ring of the MSA, which stretches into West Virginia, the average RN earned $19 per hour.

So what we see here is while wages within the MSA vary by roughly 20 percent from the center core to the outer edge, hospitals in all parts of the MSA receive wage index. Now this problem has been pointed out earlier by the GAO,

and CMS chose not to change the wage index because there was a great difficulty in trying to build consensus on how to change it. This raises the question when we look at alternatives to the current wage index, how do we plan to evaluate the attractiveness of the different alternatives?

In examining alternatives to the wage index we plan to examine, first, how well does each alternative predict costs?

Second, how well does it address the boundary problem that David talked about and in the inter-MSA problem that I talked about? Does it reduce year-to-year volatility in the wage index? Would it be simple to administer and for people to understand? And would it create an accurate wage data that could be used outside of the hospital sector? Meaning, would it also improve the accuracy of the wage index for other sectors such as SNFs and home health?

We'd now like to hear your questions and comments.

MR. HACKBARTH: To trick is that those are in conflict, potentially those objectives, and there are trade-offs to be made.

DR. WOLTER: I guess the questions I would put on the table related to this are, what does this mean in terms

of the impact once the wage index drives a certain update? For example, what percentage of hospitals are greater than one for their wage index? I think you said about one-third are reclassified. And of those that are reclassified, are they generally reclassified into a one or higher? Is it theoretically even possible, if you're not above one or you're not reclassified, to ever receive a market basket update? I'd be interested to know that.

DR. SCANLON: This is not market basket. This is geographic.

DR. WOLTER: But once the wage index is applied it does affect your update, correct?

MR. HACKBARTH: It affects the base level of payment as opposed to the update. It would interact with the update. From time to time I've heard a hospital say, my wage index went down and that offset all or part of the update. But analytically, in terms of the structure of the payment system, they're distinct things. One is a base payment issue, the other is an annual increase issue.

DR. WOLTER: But my basic question remains the same, from year to year to year can we get any sense of the different profiles of -- do people tend to fall consistently

at 1.0 and above, and how does that affect then their base payment? Institutions that are reclassified, how does that affect their payment year-to-year? And then the group that is that neither category, how does that affect them?

The basic question is, is it possible to get an analysis of the impact of this on payment in terms of the profiles of the institutions affected? It's just a question. I'd be interested in data if we could get it.

DR. STENSLAND: I think we can do that. Naturally, when you have the reclassification that increases your wage index, your payments go up. Historically, what then would happen would be they would, in the end then, make a little budget neutrality adjustment and take everybody down a touch to compensate for the fact that your payments went up by 8 percent, say, when you moved out from a rural area into the MSA.

But these new adjustments, like this new one-time reclassification, which is about $300 million a year, that can give some pretty significant update increases in payments to people, on the order of 8 to 10 percent and then that boosts them up for three years with this one-time boost of money. Then at the end of the three years it's scheduled

to go away, as Jack talked about earlier.

MR. GLASS: If you look at this graph you can see that those getting over 3 percent, so the ones -- it's that 7 percent minus 4 or less that I think you were concerned about actually getting the change in wage index that outweighed their update, correct? So that's how big that group would be in that particular year.

DR. MILLER: I'm not sure I'm following this, so if we're going to do something I want to see if I get it.

It's not so much the net impacts that you're interested in. You're interested in -- I'm asking -- if you could take a look at the hospitals, classify them into some kind of typology, people who generally stay in the same place, people who got reclassified, people who are above one and move around, or stay below one, and see over some time period what the effect has been on their base payment. Is that the question that you're getting?

DR. WOLTER: I think in a nutshell I'm just trying to understand the magnitude of the issue that we're dealing with in terms of how is it affecting payment and can we break it out in --

MR. MULLER: You have it there. I mean, the

multiplication is obviously transitive so you have 20 and 15 and five and seven, so you have almost 50 percent get less than the update because of the --

DR. REISCHAUER: Remember you multiply -- this only applies to the labor part of total costs, so you --

MR. MULLER: So 70 percent.

DR. REISCHAUER: 50 percent, I think, 52 percent.

DR. MILLER: So your point is relative to the update, Nick? That was what your question was driving at.

DR. WOLTER: Yes, I'm just trying to understand the magnitude of the distributional impact that this system has, which I don't understand exactly from these numbers.

MR. HACKBARTH: The magnitude of the impact of the year-to-year changes, or overall the magnitude of the redistributional impact of the wage index? The latter?

DR. WOLTER: The latter, but probably both.

MR. HACKBARTH: There's a wide range of wage indexes from --

DR. STENSLAND: 0.6 to 1.5, something like that.

MR. HACKBARTH: 0.6 to 1.5, and it's applying to 60-some percent of the rate -- close to 70 percent now of the rate.

MR. GLASS: Yes, the labor share is about 0.7 now almost for most --

MR. HACKBARTH: So it's a big variation in the starting point in the payment system.

DR. SCANLON: But it's meant to level the playing field, and even the changes in the negative are supposed to reflect the fact that your labor market has changed and your costs have gotten cheaper. Our problem is, how good is the index relative to what's happening in the labor market that the hospital is facing, and we've got potential significant issues there.

DR, REISCHAUER: Can you remind me where they get the basic data from, nurses' salaries, lab technicians' salaries and all of that? Are these from --

MR. GLASS: They don't do it that way. They take the average wage reported by the hospital in the hospital cost report and compare that to the national average.

DR. REISCHAUER: Undifferentiated by occupation?

MR. GLASS: The occupational mix problem -- I didn't bring it up today but they are trying to deal with that.

MR. HACKBARTH: The answer is, yes, that it hasn't

adjusted --

MR. GLASS: Right now they're adjusting 10 percent of it for the occupational mix adjustment, but the current occupational mix adjustment is somewhat questionable so they just issued a proposal to do a new survey that's going to collect occupations, their hours and their wages for each hospital. They're going to start from that and see if they can do another job on the occupational mix adjustment, because they lost a case that said they should be occupationally mix adjusting 100 percent of it.

DR. MILLER: But you've put your finger on one of the fundamental issues we're raising with this analysis which is, where should the data come from? That's one of the issues that we're going to be looking at. If that wasn't clear in this conversation, we should make it clear. It's not just messing around with the hospital-reported data and can you make this better? Theirs is a fundamental question of do you just go outside it and start working more with Census data and trying to get that to make these adjustments.

MR. GLASS: To be specific, we are looking at alternatives where you would use BLS and Census data which

would reflect not only hospital employment but all employment for those occupations in the market area. We think that might help out and also make it more applicable for other sectors.

DR. REISCHAUER: Imagine that we had perfect occupational data and it was collected by hospitals and you could figure out what the average was for each county. Why would you want to do, in and out, any kind of adjustment at all? This would be the market. This is what people are paying. Why should there be an adjustment at all?

MR. HACKBARTH: The county may not be the true market.

DR. REISCHAUER: We wouldn't have to do it by county. You could do it by zip code or something like that.

MR. GLASS: Given a reasonable approximation of the market and good data that would be the hope, that you wouldn't have to have reclassification, out-commuting and all of the other things that have been created to deal --

DR. REISCHAUER: But what is the logic for the out-commuting?

MR. HACKBARTH: That we don't have a reasonable approximation of the real market.

DR. REISCHAUER: But the reason we don't is because we don't have the disaggregated information of hours by occupation for the entity, not that --

DR. MILLER: It's more than just that. It's the data and the unit you're looking at. So if you report for a given hospital and this hospital says, I know these are the wages that I'm paying but I'm competing against somebody who can pay more and people are leaving my -- this is the argument.

DR. REISCHAUER: But then the next year they've had to pay more and the data you collect is higher, so in a sense you've been unfair for a year or something like that. But it's the most accurate measure of what the market actually is.

DR. MILLER: I understand that. I'm just telling you what drove the out-commuting change in the law.

DR. STENSLAND: I think we're exactly thinking about looking at what you're talking about, because there's this cliff that David talked about and you can address it two ways, one with out-commuting, or you could just look at the level of wages in each county and then do some smoothing between the counties and you could address the problem that

way. So there's definitely another way to address it.

MR. DeBUSK: In the rural setting there's another situation that has evolved or perhaps it's been there to some degree all along, and that's supply and demand. Let me give you an example there in the Appalachians. In Middlesboro, Kentucky a nurse can start at that local hospital for -- within six months you're at $22 an hour. Folks, this is in rural, rural America. There's very little supply. So you've got these small hospitals that are really pressed to make it and they're paying wages equal to Washington. This is going on because of supply and demand. This is another extreme, in one sense, but probably is very realistic throughout all those mountains. So you've got people here that are really going to struggle with those kinds of costs, and it goes throughout the whole spread of professional people.

DR. SCANLON: The data on slide 10 which had you mentioned were from the GAO report, and this is the Washington MSA and that third ring is part -- the West Virginia counties are there. The actual wages being paid in those hospitals are $19 compared to in D.C. we're paying $24. But the West Virginia hospitals are benefitting.

If you look at the MSAs, except for New York City, the MSAs are dominated by the hospitals in the central cities. So therefore, the outlying hospitals all benefit from the higher wages in the central city even though, as Bob's point, they're not paying those wages. Their staffed and this is what they actually paid was the $19 but they're getting something closer to a wage index based upon $24. In your world, where you had more realistically defined labor markets everybody would be getting something more comparable to what they actually pay.

DR. STOWERS: Bill, you lose me when you say they benefit because being on the board of a hospital that was about 60 miles out and in the third ring, all of our supply and demand thing that Pete was talking about was willing to drive, so our need got a lot worse, so we had to pay more than the $19. So I'm trying to figure out how we --

DR. REISCHAUER: But if you do it will be reflected in the index.

DR. SCANLON: In the data. But the people in West Virginia aren't.

DR. STOWERS: Not for that individual hospital though.

MR. HACKBARTH: Everybody's going to face the same supply and demand within the geographic area, unless you're talking about --

DR. STOWERS: I just want to reiterate, and everybody's aware of the Congressional thing, it is very much a chicken and the egg because you're sitting on that board and something makes up 60 or 70 percent of your overall budget then it's not like that money is going to come from -- so you're kind of trapped and an ability to --

MR. HACKBARTH: There are issues about a lag in the data. Wages quickly spike up, the data aren't collected continuously, and so there can be a temporary problem due to that. That's a given.

But I think Bill's point is that hospitals are getting reclassified into areas that give them wage indexes that are really much higher than the actual wages that they're paying. That happens to, and it's happened in a big way.

DR. SCANLON: And there's a group of hospitals that benefit without reclassification because they are on the fringes of an MSA. They didn't fall off the cliff. They're on this side of the cliff and yet they're really a

long way from the central city where the wages are so much higher.

MR. HACKBARTH: What makes this area challenging is there are lots of data issues in trying to get the right data and then in formulating the right adjustments. We've got these trade-offs among competing, potentially conflicting goals and we've got to figure out what the right strategy is for that. Then the third piece is, politically it's very complex, especially in an era where we've had a lot of people reclassified into areas where their payments are much higher than their actual wages, they're going to be very reluctant to give that up. So this is complicated every way you look.

Any other questions or comments on wage index research?

DR. REISCHAUER: There's one thing to point out and that is for every person who's getting, in a sense, too much, there's somebody who's getting too little because of the way this thing works out.

MR. GLASS: Except with the recent changes where we're trying to strive for everyone to get above average.

MR. HACKBARTH: That used to be the rule of the

game. No more.

We are at the public comment period on the morning session.

Carmela, before you begin let me do my usual little spiel. We want to have as many comments as possible and so we urge you to keep them brief and avoid repetition. Feel free to come up and say that you agree with a previous speaker. That's fine. Go ahead, Carmela.

MS. COYLE: It looks like it will be short by the size of the line. Carmela Coyle with the American Hospital Association.

Wanted to say that we appreciate the Commission's efforts to again begin to address this issue of efficiency which is clearly a very difficult, a very challenging one. It really is difficult to assess other than on a case-by-case basis. But would urge some caution in the analysis that was presented this morning about throwing out the one-fifth or the 800 high-cost hospitals, perhaps without a better understanding of what's driving those high costs.

Layer on top of that, I think what you're looking at and what was presented in terms of expected 2006 Medicare margins, not only expected cost increases, whether it's

clinical technology, information technology, issues around Sarbanes/Oxley compliance, whether it's projected payment cuts. I heard staff suggest that in those calculations were the geographic reclassification changes that are expected. Didn't hear a specific mention of the transfer changes that are also coming down the pike to the tune of reducing hospital payments by $1 billion in 2006, another $1 billion in 2007. It may be in there; just wasn't clear.

MR. HACKBARTH: It is.

MS. COYLE: Thanks, that's very helpful. But I guess the bottom line, taking a look at some of the data that was presented this morning for the three for-profit chains, about 300 hospitals, where costs were increasing at 5 percent, one might argue that that's a set of hospitals that has an even stronger incentive to maintain, reduce costs where they can. Yet juxtapose that with the proposed recommendation, market basket minus half the productivity increase, which would yield about a 3 percent update. So you've got 5 percent costs and at least in your discussion today a potential for only a 3 percent update. I think the suggestion is that payments are inadequate. Even as you project it out, you're looking at negative or zero margins.

Would just ask you to reconsider a higher recommendation at your January meeting.

A second issue is on the outpatient hold harmless. Would strongly encourage this commission to extent that hold harmless for another year. Basically, a recommendation you made last year. As you do your work over the next month there are about some 600 hospitals that benefit today and are assisted by that hold harmless. Under a 25-mile limit test only about 150 . I think it's that better understanding of who are those 450 hospitals in the middle.

Just one story, because your conversation went to this. Many of the hospitals that have been changing to critical access hospital status have had to squeeze down under that 25-bed limit. Many have done so by discontinuing their OB/GYN and their delivery services. It's those other 450 rural hospitals that are the ones left delivering the babies in this area. So the financial struggle for those critical access hospitals, the choices they've made, I think we have broader societal benefits by still being able to deliver babies within a 50 or 60-mile radius those other hospitals. Just encourage you to look at those 450.

Thanks.

MR. HACKBARTH: All right. We will go to lunch and reconvene at 1:30.

[Whereupon, at 12:09 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:39 p.m.]

MR. HACKBARTH: While people are taking their seats, could I have your attention?

I want to just talk for a second about the weather. Since we don't have anything else to talk about, let's talk about the weather. As everybody knows, the forecast is for snow tonight. Last I heard was two to four inches in the District, four to six. I've got one to three over here. Do I have another offer? The probability of accuracy is -- who knows?

At any rate, I think we would be well-served if we just think about possibilities for tomorrow.

Even if there's a relatively small amount of snow, it would not be unusual for the Federal Government to either close its offices or have a delayed opening, something like that, or a liberal leave policy.

Barring an unforeseen level of snow, we are planning on having our meeting tomorrow, our public meeting. So that's a message for Commissioners and staff and the public audience. In a minute, Mark, I'll let you address the staff issue if you want to do that.

So don't be put off by what you see on the morning

news. Try to make it here with -- obviously safety is the first priority. If it's so bad as to compromise that, don't come.

But we're going to do whatever we can to have our meeting tomorrow for the simple, very practical, reason that we don't have any alternative. We can't reschedule and we've got work that we've got to do and now the deadline is near, with January quickly upon us.

Mark, do you want to say anything about staff?

DR. MILLER: No. The only thing I was going to say for staff was exactly what you said. Try and come unless it compromises your safety.

MR. HACKBARTH: Any questions from Commissioners on that?

DR. KANE: Is there a number you can call?

MR. HACKBARTH: Mark at home. Starting at 3:00 a.m., Mark will take calls.

DR. MILLER: That number is 555-1212.

In all seriousness, usually what I do in these situations, although I've forgotten the number since last year, there's a number I call to find out what the Federal Government is doing. And then we had a system to enter the

phone for staff to call at MedPAC. I can give you, at the end of my meeting, my cell phone.

But I think the mission here is even if the Government is going to be delayed or liberal leave, or whatever it is, I think we're leaning forward to do this.

MS. DePARLE: Is the building going to be open tomorrow?

DR. MILLER: That's a good question. Annissa, can you check on this?

MR. HACKBARTH: Let's turn now to the agenda, which has us moving on to assessment of payment adequacy for dialysis.

MS. RAY: Good afternoon. Today's presentation on outpatient dialysis is composed of three parts. First, I will provide you information to support your assessment of the adequacy of Medicare's payments. Second, I will present last year's recommendation about updating the composite rate -- that's the payment rate for dialysis treatment -- updating the composite rate for calendar year 2007. And third, I will briefly update you with new information about Medicare's payment for drugs in 2005 and provider's ability to purchase drugs.

The first part of this presentation focuses on payment adequacy. The factors of payment adequacy are presented on this slide. Today I will be focusing on beneficiaries' access to care, changes in the volume of services, and Medicare's payments and costs in 2006.

Recall in October we discussed providers' capacity to meet patient growth, changes in quality of care, and providers' access to capital. I just want to briefly recap those results.

First, providers appear to have sufficient capacity to care for patients as measured by the growth of facilities, hemodialysis stations and patients.

Moving on to dialysis quality, it is improving for some measures like dialysis adequacy and patient's anemia status. One measure, nutritional status, has showed little change over time. Nancy-Ann, you raised a concern about this lack of improvement in October. After considering this issue in the chapter, we include a statement strongly urging the Secretary to include malnutrition as one of the initial measures used to link payment to quality.

Regarding access to capital, indicators such as recent financial information, access to private capital to

fund acquisitions, and evidence about the increase in dialysis facilities suggest it is adequate.

Regarding beneficiaries' access to care, we began to talk about this in October and we see that it is affected by certain local issues. In addition, the proportion of providers offering in-center hemodialysis -- nearly all -- and peritoneal dialysis -- about 45 percent -- has remained constant over the past five years. In the back of the chapter that was enclosed in your mailing materials I have included a new section on some of the factors that may be affecting the use of home dialysis.

Now let's move on to some new information for you to consider.

Last year we found that facility closures may be disproportionately occurring in areas where a higher proportion of the population is African-American. However, this finding was derived from an analysis of area level data. Area level analyses cannot speak about the patients treated by a specific facility.

Therefore, we conducted a new analysis that linked patients to the facilities that cared for them. We divided facilities into three groups: those that newly opened in

2002, those that closed in 2002, and those that remained in business in both years. The objective here was to assess whether certain beneficiaries are disproportionately affected by closures.

In addition, we also wanted to see whether new facilities are disproportionately caring for certain groups versus other groups.

I'd like to highlight three results. First, the characteristics of the patients treated by facilities that closed and those that newly opened were similar. About a third of the patients were African-American. Nearly half were female. And nearly one quarter were elderly and about 40 percent were dual eligible.

In 2002, providers' capacity to furnish care increased on net by 131 facilities and about 2,000 hemodialysis stations. Third, facilities that remained in business in both years treated a greater proportion of patients that were African American and dually eligible for Medicare and Medicaid. These results together suggest that beneficiaries should not be experiencing problems accessing needed care.

I'd like to point out a couple more results we

found from this analysis. First, the closures of the facilities in 2002 may be linked to their profitability, size and economies of scale. For example, the Medicare margin for the closed facilities was negative 5 percent in 2001 but was 4.1 percent for the facilities that remained in business.

Second, closures do not seem to appear to affect rural beneficiaries disproportionately. About a quarter of facilities are located in rural areas, looking at closed facilities, newly opened facilities and facilities that stayed in business.

Finally, the share of Medicare treatments was somewhat lower for newly opened facilities at about 74 percent, compared to their counterparts which was between 78 percent and 79 percent. Some dialysis providers have informed MedPAC that the payment rates of commercial payers exceeds that of Medicare's and Medicaid's rates and the difference in the payment rates between the commercial payers and the government payers may be influencing their decision about where to open facilities.

In conclusion, the findings from this analysis and our other analyses that we presented in October suggest that

beneficiaries should not be experiencing systematic problems in accessing care.

We looked at trends in the volume of services furnished to patients. We look at it in terms of changes in annual spending between 1996 and 2004 because that is the unit that is common between composite rate services and separately billable dialysis drugs. Total payments have increased about 8 percent per year for composite rate services, 13 percent per year for erythropoietin and 18 percent per year for other drugs.

To put these growth results in perspective for you, dialysis patients increased roughly by about 5 percent per year during this time and drugs share of total dollars for a given facility has increased from about 31 percent in 1996 to 42 percent in 2004.

Let's move to our analysis of Medicare payments and costs. We looked at providers' Medicare allowable cost for the most recent year that data is available. For this analysis, I used 2003 cost reports, not 2004. Let me explain to you why I did not use 2004 cost reports. In 2005 CMS required providers -- dialysis facilities -- to begin to file their 2004 cost reports electronically. By all

accounts, they did so. However, the fiscal intermediaries are still processing many of these 2004 cost reports. The file that we received from CMS did not include a sufficient number for us to proceed with an analysis using the 2004 reports. Thus, we are using 2003 data.

So our results here show little change from what we found last year using 2003 cost reports. Costs per treatment grew roughly 2 percent annually between 1997 and 2003. In the most recent year, that is between 2002 and 2003, costs decreased by about 1 percent.

Between 1997 and 2003 there is some variation in cost growth, ranging from 0.2 percent for low-growth cost providers to 3.7 percent during this time period.

Moving to the audit factor. Our margin analysis is based on costs being Medicare allowable. That is why we have considered and continue to consider how CMS's audit efforts affect the level of costs. 2001 is the most recent reports that have been audited. The most recent 2003 file we have shows that 20 percent of these reports have been settled with an audit. For facilities whose cost reports were settled by an audit, the cost per treatment for composite rate services decreased from about $144 to $137.

By contrast, their drug costs remained essentially the same.

Therefore, we determined the Medicare margin by applying an adjustment of 94.5 percent, that is the ratio of 136 divided by 144, to the cost of composite rate services for facilities whose cost reports have not been settled yet by CMS.

So here is the Medicare margin for both composite rate services and dialysis drugs. It was 5.5 percent in 2000, 2.4 percent in 2003. We project it will be negative 2.9 percent in 2006.

If, however, we assume that providers will achieve a 6 percent margin on average from dialysis drugs in 2006, and they will be paid average sales price plus 6 percent in 2006, then we project the margin to be negative 1.7 percent.

To give you some feel for the variation around the margin, in 2003 it ranged from a negative 0.3 percent for nonprofits to 3.7 percent for facilities in one of the four national chains. They compose about 70 percent of all treatments.

So now the second part of our update process is to consider the cost changes in the payment year we are making a recommendation for, that's 2007. Here CMS estimates their

market basket increase would be 3.2 percent and our productivity growth factor is 0.9 percent.

I'd like to start your discussion about payment adequacy and updating the composite rate with last year's recommendation, and that is that Congress should update the composite rate by the projected rate of increase in the ESRD market basket less half the adjustment for productivity growth. Again, this will be for calendar year 2007.

Spending implications: this will increase spending over the baseline. There is no provision in current law to update the composite rate in 2007.

Updating the composite rate will maintain beneficiaries' access to quality care. It will increase beneficiaries' copayment, as well as increase providers' payments.

Finally, before you begin your discussion about payment adequacy, I'd like to just very briefly talk about the policy change in how Medicare paid for dialysis drugs in 2005. This is the first year that Medicare based payment on acquisition costs. Providers were paid an average acquisition payment. Some stakeholders were concerned providers might not be able to purchase the drugs below

Medicare's payment rate. MedPAC acquired pricing information for the top 10 dialysis drugs from a commercial data source. We tracked trends in the average purchase price and price variation from the first to the third quarter of 2005. Our results suggest that in 2005 the average purchase price of most drugs used by dialysis patients decreased and that freestanding dialysis providers could generally purchase drugs at less than Medicare's payment rate in 2005.

That concludes my presentation. I'll put the draft recommendation up and look forward to your discussion.

MR. HACKBARTH: For those who weren't here this morning, let me just say a word about the draft recommendation. The draft recommendation is what we recommended last year for the update for dialysis facilities. And so I would urge people not to read too much significance into that. It is simply a carryover from last year.

Nancy, could I ask a question about the table on page eight? I need to get my thinking straight here because I'm used to our old approach where we used to have the margin based on the composite rate alone and then the margin

based on the composite rate plus the drug expenditures, and there have been changes in the rules of the game.

When you introduced this table, I thought that you said these are the margins on the composite rate. This includes both a composite --

MS. RAY: This is the aggregate margin for composite rate and dialysis drugs.

MR. HACKBARTH: So this is sort of the combined margin?

MS. RAY: Yes.

MR. HACKBARTH: And then say one more time the difference between the 1.7 and the 2.9.

MS. RAY: That negative 1.7 assumes that providers can achieve a 6 percent payment margin on drugs.

MR. HACKBARTH: Another words, if they can get it at the ASP?

MS. RAY: Yes. The negative 2.9 does not make that assumption.

MR. HACKBARTH: What does it assume about the level at which they can buy the drugs?

MS. RAY: It assumes the normal cost growth, which we assumed to be at the PPI in 2006.

MR. HACKBARTH: Okay. Questions, comments?

MS. DePARLE: Nancy, thanks for the more detailed explanation about the data and the lag in it.

It sounds like, from our conversation, that we won't have 2004 data in time for you to do your analysis for this year. Is the glitch that occurred something that we understand has now been corrected so that for coming years we'll have better data?

MS. RAY: That's a good question. We will follow up with that.

MS. DePARLE: This was supposed to make it better by enabling the providers to do this.

MS. RAY: It was. We will follow up and get back to you on that in January.

MS. DePARLE: You put up your slide about the audit factors, is what you're calling it I guess, which we've had discussions about before here. Will the new way that the FIs are collecting the cost reports do anything to make that easier or unnecessary? This is an extra step that you take in analyzing the data; correct? Because you've determined that there is a discrepancy between allowable costs and what some of the cost reports show that facilities

are actually claiming.

Will this new way of collecting the data do anything to make that less necessary or not?

MS. RAY: I don't think so. I don't think so.

MS. THOMAS: My understanding from the transactions between Nancy and the person at CMS is simply that they're submitting it electronically. There's no difference to the quality of data, it's just all uploading it electronically.

MS. RAY: Yes.

DR. SCANLON: I was going to respond that there are other providers. It's been something that CMS and HCFA have done in the past, in terms of doing an audit and making an adjustment to construct the PPS rates. Because there is always a problem of --

MS. DePARLE: I'm aware of that. I don't know that it's a step that we take with every provider, though; is it? This is something that's just for dialysis where MedPAC applies an audit factor, and that's what I've objected to in the past. I'm certainly familiar with audits.

DR. MILLER: The reason that we do here is that

actually somebody went through the exercise early on and estimated an audit factor here. And that's what we've been kind of working off of and doing some more recent estimates of our own.

MS. RAY: Just to follow up, ProPAC originally looked at the difference between cost reports that were audited versus those that were not. And then I looked at a fair number of the 1996 cost reports were audited and that's what we had used up until last year when we saw that last year 11 percent of the 2001 cost reports were audited. This year we found that of our 2001 batch, 20 percent are now audited.

MS. DePARLE: That's better. But the problem I have with it is that it's very lagged. We've talked here before about the slight percentage of reports. It sounds better, at least, 20 percent. But the slight percentage that are audited, the lag in it disturbs me, having it apply from 2001 to today across the board.

My main concern is that if we're going to do this -- I've said this in previous years -- if we're going to do it, we should do it for all sectors, not just for dialysis.

DR. MILSTEIN: A couple of questions. The first

is partly a carry forward of momentum from the pre-lunch discussion.

Am I right, have we or have we not previously profiled dialysis providers in a manner similar to what we were shown for hospitals? So we can begin to sort of think about this problem using the MMA reference point of what an efficient dialysis facility needs to generate positive Medicare margins? Have we done that?

I guess the even more important question is if we have done it, does it generally show that there is a substantial slug, a segment of this industry, that has robustly positive Medicare margins?

MS. RAY: We did an analysis several years ago in which we looked at providers' costs and their quality of care. There we found that higher costs are not necessarily associated with better levels of quality. We have not specifically tied that analysis here into the update analysis.

I guess the other thing that we did show back in our June report is that dialysis quality, at least for dialysis adequacy and anemia status, doesn't vary that much between the different provider types.

The third piece of information we do know in all of this -- I guess the short answer to your question is we have not integrated in this. But we also know that the more efficient providers in this group tend to be those affiliated with the four largest chains.

DR. MILSTEIN: My second question is -- and I guess this pertains to this but it also relates to the prior discussion. If we believe the IOM report, that this is an industry -- I don't mean the dialysis industry only, but the health care industry -- is an industry that is not really what, benchmarked against other industries, we would deem to be lean in the manufacturing sense, what is the rationale for suggesting that the subtraction for the productivity factor be half of what's being achieved in other industrial sectors?

An argument could be made since the baseline is less efficient, it should be double.

MR. HACKBARTH: The rationale in this case is that in dialysis last year, as was true in hospitals, we had indications that the margins had gone from being positive to being negative. And so cutting the productivity adjustment in half was a way of easing off the pressure in view of that

development.

DR. MILSTEIN: I'll stop. The linkage to my prior question would be if we were to determine that a very substantial fraction of the industry has positive Medicare margins. Despite this equilibrium, that might reduce the rationale for cutting the productivity expectation in half.

MR. HACKBARTH: Right, and in keeping with the efficient provider mandate that Congress gave us in MMA, in this sector as in others ultimately we want to be looking not just at average margins but try to hone in in various ways on what that most efficient provider -- considering both cost and quality -- is producing, and start gearing our recommendations to that. That is definitely the objective.

Nancy you, in your initial response to Arnie, alluded to our earlier research, didn't you, about the relationship between cost and quality. And we found that there was not a direct relationship between higher cost and higher quality.

Although, as I recall, that analysis focused on the composite rate services as opposed to the larger bundle; is that correct?

MS. RAY: Right. We did it both ways. We looked

at the composite rate. Than we put composite rate and drugs together. And there we found that it was an inverse relationship.

Part of that reason could be due to patient case mix, which we made some adjustment for. But it may not have been as complete as necessary.

MR. HACKBARTH: Let me just play that back, to make sure I understood correctly. When we added in the drugs, you're saying that there was actually lower cost institutions were associated with higher quality but the residual concern about that is whether we had adequately adjusted for the case mix difference.

Other questions or comments on this?

MR. DeBUSK: [off microphone] Nancy, I'm going to ask you a question about a statement the industry makes and I'd like to hear your comment. They say access to care has very little to do with Medicare economics. If it were not for commercial payers who grossly subsidize the losses incurred by treating Medicare beneficiaries, there be a major issue in access of Medicare beneficiaries. Is that true or false?

MS. RAY: I think we see that on average the

payment rate from commercial providers is greater than Medicare and Medicaid's payment rate. I think it's important to recognize -- and that for about 25 percent of new ESRD patients, Medicare is the secondary payer. The commercial payer is the primary payer. After 33 months, then Medicare becomes the primary payer.

MR. DeBUSK: [off microphone] So the answer is what?

DR. MILLER: I'm sorry, I lost track of the second half of the question.

MR. HACKBARTH: Would you repeat the question and hit your mike.

MR. DeBUSK: The industry says access to care has very little to do with Medicare economics. If it were not for commercial payers who grossly subsidize the losses incurred by treating Medicare beneficiaries, there would be a major issue in access of Medicare beneficiaries.

I was just asking is this true?

DR. MILLER: What we do know is that, at least when we look at use of services and access for Medicare beneficiaries, we did not see that they are having access problems. And to the extent -- I'm going to get there, I

know where you're going.

And to the extent that we're observing negative margins here, we're acknowledging the payment issue and making a recommendation to address it.

MR. DeBUSK: Let me take this out to the people who pay the bills for all of this stuff, the manufacturer out here in the industry today. The cost of a dialysis patient to a company this unbelievable. It can actually mean the difference in a profit or a losing situation on a month to month basis.

It's our mission to pay the fair share, what's right. And there's places, it's quite evident, that we don't pay our fair share. You want to talk about jobs leaving this country, where it gets down to, I work 2,500 people and you can believe I'm forced to take them out of this country. But right there is one area that really, really hurts industry a great deal.

You wonder is this good policy? Are we doing what we need to do for this sector of our elderly patients? It's questionable.

DR. REISCHAUER: Let me just reiterate something that I've said a number of times before, which is I would

hope that we would do the capacity of the industry and the access issue more in terms of stations than in terms of centers because, as your information shows, the average size of a center, in terms of stations, seems to be growing over time. This seems to be driving a lot of the efficiencies, economies of scale, that we're talking about.

I'd like to know -- and the differential margins between the freestanding ones and the chain ones. If I go to your numbers for 2003, I think you have a 3.7 percent margin for the chains 2.4 overall, which means the balance of the industry has a negative margin in 2003.

And so I think, in a sense, it's incumbent upon us to ask where those are and are the chains spread out in rural areas as well as in urban areas? I don't know the answer to that, but I think we need to look at this in a lot more fine-grained kind of way.

And I'm perfectly comfortable, unlike Pete, that we're doing the right thing. We see overall negative margins or compression here, and are making an appropriate kind of response to that situation. But if it really is a big chain versus the others story, we have to ask ourselves about the others and are they the equivalent of critical

access hospitals or whatever, and the chains unwilling to go into rural areas or certain areas?

I don't think that is the case but I'd like to know.

MR. HACKBARTH: Any comment on that at this point? Or is that something you can bring back for January?

MS. RAY: We'll look into the feasibility of trying to put some maps together to look at the location of facilities and their margin and their chain status, yes.

MR. HACKBARTH: Others?

MS. HANSEN: Can I ask a little bit more what was in the report and not on the slides, relative to the home dialysis or going further down over time?

But that there were some cost savings that tended to occur, I think, with the home dialysis but that there were other multiple reasons why people might prefer going to the in-center.

Is there any thought about the difference? Are there any qualitative differences in the quality of complications or anything like that if somebody does dialysis at home as compared to in-center?

MS. RAY: There is literature about that. I think

that's something that we would need to explore more fully in the future. I think our section on home dialysis is a starting point for us to look at this issue.

DR. MILLER: I think here what we're trying to accomplish is to put a marker down that it was an issue that we cared about that we were going to look into it and we really haven't moved very far on it. But we wanted to just sort of say this is the direction that we want to go in to see if, in fact, anybody had any reaction or guidance to it and so that the public knows that it's something that we are going to pursue but not much to say about it right at the moment.

MS. DePARLE: On that point of home dialysis, I'm looking for my notes here. You have some data in here that was very good about patient satisfaction with home dialysis, the likelihood that a patient would use it and that kind of thing. And then I think you talked about the reimbursement difference being on the drugs and I guess raising the question of is that part of the reason why more people don't use home dialysis.

If we think we would like to encourage that as a good alternative for patients it seems to me one of the

areas we need to look into is as something changed -- because you suggest that perhaps one reason why the other drugs aren't reimbursed is because there are safety issues with giving them in the home. Am I conflating two sections? So should we look at that is what I'm trying to get to?

MS. RAY: Again, like Mark said, this is a marker for an area that I think we want to explore more.

The point I raised in the paper is that the profitability under pre-MMA payment policies may have influenced providers' decisions to go in-center versus home dialysis because there is evidence that suggests that home dialysis patients use, on average, less drugs than in-center patients.

Under post-MMA payment policies, where we've taken much of the profit margin out of drugs, one question is what's going to happened there?

The other issue is that Medicare right now pays for erythropoietin when it's administered by a patient in his or her home. It does not pay for other dialysis drugs.

MS. DePARLE: That was the issue I was looking at.

MS. RAY: One issue to explore here is the safety of patients administering some of the other drugs that are

often used. I have heard from at least some providers that there may be a question about the safety of patients administering injectable iron, for example. But that clearly is an issue that we need to explore.

MS. DePARLE: We do. And we also, in addition to the safety, is it clinically less efficacious if some of those drugs aren't available? And if so, no wonder clinicians aren't recommending that people are doing at home, if they also can't get reimbursed from Medicare.

So there's a whole bunch of issues there but I hope we will -- I know you're interested in this. I hope we'll spend some time exploring it.

DR. MILLER: I hate to ask things that I don't know the answer to or even have a sense of, but my recollection on the auditing, this is to go back and try and give you a better answer than you got the last round from me.

My sense on the ESRD is that they're actually required by law to be audited. But they've done it more than they've done it in some of the other areas. I think some of the reason that we focus on it here is that we have -- and this is what I'm really worried about saying -- some

greater degree of confidence when you compare an audited to an unaudited report. Something has actually happened to it.

Whereas in the other sectors when you refer to audited reports it's often not that they've really audited the report. For example, in the hospital sector generally there's not a lot of it that goes on. And when it goes on, it's looking at the pass-through payments only and not the rest of the cost report.

So I think some of our thinking here is we have a little bit more of a leg to stand on here.

MS. DePARLE: I'm looking at Senator Durenberger, maybe he can answer this. Why is it that by statute those are required to be audited and others aren't? Does anyone know?

MS. RAY: I forget. I think it was the BBA that required it. And you know, my recollection is ProPAC made a recommendation calling for the regular audit of margins, again going back in history.

MS. DePARLE: So it goes back to audit factor.

DR. MILLER: Do you know what motivated if here, as opposed to somewhere else? Was there some kind of IG report?

MS. RAY: You mean what motivated the ProPAC recommendation?

DR. MILLER: I just want you to know, she's sniping at me from the sideline here.

MS. RAY: I'm sorry what motivated the ProPAC recommendation? I don't know. I don't know what motivated the inclusion of this provision in the BBA.

MR. HACKBARTH: Anybody else?

Okay. Thank you, Nancy

Next is inpatient rehab.

DR. KAPLAN: As Glenn said earlier, this is our first payment adequacy assessment for inpatient rehabilitation facilities, also known as IRFs.

The IRF PPS began on January 2002 and Medicare spending for IRFs is $6 billion in 2004.

I'm going to briefly review the factors for these facilities that I presented in October, and then Craig and I will present new information to inform your assessment of adequacy and the update recommendation.

Factors from October include supply of IRFs, volume of services and spending, and access to capital. From 2003 to 2004 the number of IRFs entering the Medicare

program increased 1 percent. At the same time, volume of cases increased 4 percent and spending increased 5 percent. IRFs appear to have access to capital. 80 percent of these facilities are hospital-based and have access to capital through their parent institutions. As you heard this morning, hospitals appear to have good access to capital.

Today the new information includes changes in quality, new information on volume, changes in access, and payments and costs.

To assess changes in quality of care for IRFs we use a measure commonly tracked by the industry, the difference between the discharge and admission scores for the commonly used functional independence measure, known as the FIM, which is incorporated in the assessment tool for IRFs. The FIM measures physical and cognitive functioning using 18 items that have a score ranging from one to seven for each, with one the highest and seven the lowest.

In short, we are interested in whether there is no change, with stable scores; an increase in the difference, which would be improvement; or a decrease, which would be deterioration. To compare quality at a national basis we used the average difference in FIM at discharge versus

admission for Medicare patients in two ways, as shown on the screen. These scores suggest that quality has remained steady under the PPS.

To be paid as an inpatient rehabilitation facility, IRFs must have 75 percent of patients admitted for one or more of a list of conditions. CMS changed the conditions considered appropriate for intensive rehabilitation, as you can see from this graphic. Polyarthritis was no longer included and the conditions you see on the right were added. Polyarthritis was the rationale for joint replacement patients which made up a large share of IRF admissions, 27 percent in 2004.

CMS has said that the growth in joint replacement patients treated in IRFs is what prompted their concern.

CMS's intention was to change the mix of patients in IRFs by redirecting the least complicated cases to other settings for rehabilitation, in addition to differentiating between IRFs and other settings.

In 2005, when the threshold was 50 percent, the volume of cases decreased an estimated 9 to 14 percent. The 9 percent decrease comes from the IRF industry. The 14 percent decrease is the result of our analysis of the first

half of 2005 compared to the similar period in 2004. Our results are more conservative.

Not surprisingly, joint replacements have decreased the most. However, there have been increases and decreases in other cases, as well. A separate issue, which we need to examine further, is the effect of CMS's guidance to the fiscal intermediaries in program memoranda that appears to be driving some of the decreases.

Access is hard to judge in any case. We know that IRFs are not located everywhere. There are questions of clinical appropriateness, who needs intensive rehabilitation in an inpatient setting, especially in the context that rehabilitation can be provided less expensively in other settings.

We don't know what to tell you about access in this area. On the one hand, before 2005 there were increases in volume, IRFs, and Medicare spending. On the other hand, there are the declines in volume in 2005.

MR. LISK: We will now move on to examine factors that affect payments and costs, the last component of our update framework. The above graphic shows how length of stay has changed cumulatively since 1998 for IRFs. As you

can see, IRFs have experienced length of stay declines every year for Medicare patients. The length of stay declines, however, slowed somewhat after the implementation of the IRF PPS.

What does this mean for cost growth? This chart shows the cumulative change in payments and costs per case since 1998. From 1991 to 2001, under TEFRA, we actually saw in aggregate a reduction in payments per case and costs per case. With the introduction of the prospective payment systems for IRFs, however, we actually saw a huge increase in payments per case of over 10 percent per year 2002 and 2003 as hospitals transitioned in to the IRF PPS over this period.

Along with this rapid increase in payments came an increase in costs per case of appeared to be lagged one year, an increase of 2.4 percent in 2003 and 3.6 percent in 2004. Needless to say, this big jump up in payments led to a rapid rise in Medicare margins for these facilities.

As you can see, the Medicare margin jumped up substantially with the implementation of the IRF PPS, from 1.5 percent in 2001 to 11.1 percent in 2002, rising further to 17.7 percent in 2003 when all IRFs were under the PPS.

In 2004 the Medicare margin was 16.3 percent.

I want to make you aware, though, that there are some issues with HealthSouth's cost reports. HealthSouth is the biggest provider of IRF services in the country. We have attempted to adjust 2002 and 2003 for missing cost information for these facilities.

In addition, there are some reporting issues that likely result in an underestimate of Medicare allowable cost for Health South in 2004. If HealthSouth data were excluded from our analysis, the 2004 Medicare margin shown in the overhead would be about 3 percentage points lower than what is shown.

Before the PPS for IRFs, Medicare margins for free-standing and hospital-based IRFs were similar, both about 1.5 percent. After implementation of the IRF PPS, however, while Medicare margins rose rapidly for both sets of providers, the increase was much bigger for the freestanding facilities. The differential was due mostly to bigger increases in Medicare per case revenues for the freestanding providers rather than differences in cost growth. Overall essentially every group of hospitals we examined by location, ownership, teaching status, et cetera,

had double-digit margins in 2004.

Overall, however, we see that 73 percent of IRFs had positive Medicare margins in 2004. For-profit and free-standing facilities had the highest margins. Rural IRFs, government IRFs, and facilities with a low Medicare patient share -- that is less than a 50 percent patient share -- had the lowest margins. But almost all were still in double-digit range.

There's wide variation in Medicare margins. A quarter of all IRFs had a Medicare margin of 24 percent or more.

So what do we expect will happen in 2006? We have modeled 2006 payments and costs for IRFs using updates and taking account of policy changes that affect payments in 2005 and 2006. These include updates of 3.1 percent and 3.4 percent in 2006, a change in the outlier threshold which increased payments somewhat, and an adjustment for coding improvements which resulted in a decrease in payments.

The biggest change we modeled, however, was the implementation of the new 75 percent rule which Sally discussed earlier. To model the 75 percent rule for 2006, we assumed that at least 65 percent of IRF hospitals'

Medicare cases will be compliant, the standard required in 2007 in terms of the list of conditions that Sally presented to you before.

As Sally has already discussed, we have seen a 9 to 14 percent decline in cases as hospitals try to become compliant with the 50 percent standard in 2005. Projections indicate a drop of as much as 29 percent in cases in order for hospitals to become compliant with a 65 percent threshold that will be in place in 2007.

To account for this drop in cases, we have made assumptions about the reallocation of overhead and patient care costs for these patients. In our model we've assumed that discharges will fall by 29 percent and 75 percent of overhead costs and 10 percent of patient care costs related to these patients will be reallocated among the remaining patients in the hospital.

Using these assumptions, we find that Medicare margins will drop from 16 percent in 2004 down to about 8 percent in 2006.

If we have to change these assumptions to make more or less conservative assumptions it would have the effect of moving the 2006 margin up by as much as 4

percentage points or down by as much as 3 percentage points.

If Senate provisions that are in their reconciliation bill pass and become law, it would hold the compliance threshold at 50 percent in 2006 and 2007, and we would anticipate that the Medicare margins would be in the range of 4 to 7 percentage points higher than we have shown here.

DR. KAPLAN: This is the first time we've recommended an update for IRF. The draft recommendation is the Congress should increase payment rates for the inpatient rehabilitation facility prospective payment system by one-half of the protected market basket for fiscal year 2007.

Up until recently IRFs had an increase in cases. Volume is down now because of the 75 percent rule. We made a conservative estimate and they still have healthy margins.

We're ready for your questions and comments.

DR. MILLER: Glenn asked me to just make a couple of clarifications and then maybe make a point for the Commissioners and the public that might be a natural question.

Some of this is pretty complicated here. We have a 75 percent rule cutting into or being implemented over the

next couple of years. That's going to have the impact of potentially reducing discharges or admissions in these facilities. So we made an assumption that, at this point in the implementation of the rule, where they have to comply with what -- the 75 percent rule at that point is you have to be 65 percent. That means a third of the admissions, in round numbers, we're assuming leave the facility and that they don't replace them. That's a fairly aggressive assumption. And then we made some assumptions about what costs remain, and I want to make sure I get this right, but we assume that the fixed costs, about 75 percent of them stay and about 75 percent of the variable costs stay.

Now it might be a natural question, and this is what Glenn was looking for me to clarify, for someone to say tell me about the relative profitability of the people who left versus the people who stayed. We're not able to estimate that very directly because we can't estimate the profitability of the given payment category, much like all of the work that we had to go through on the inpatient site to figure out the profitability of the DRG. So we can't give a direct estimate of that.

But what Craig was saying there, when he was

talking about the pluses and minuses, what we did was more and less aggressive assumptions about how much cost hangs around after these discharges leave and that's what gets the range. That's what we're trying to play with to see what the potential margin would be.

This started off as a clarification and I get the distinct sense that I lost everybody in the room. So with my work done here, I'll turn off the microphone.

MR. HACKBARTH: It was a nice try.

Questions, comments?

DR. KANE: I'm trying to understand something here. Is the 16 percent margin something that we feel needs to be preserved? I don't really fully understand what's going on. Or moved down to seven?

People looked at different industry segments and for some a zero margin was okay, for some a 1 percent margin was okay. Now we're looking at a segment where -- we're recommending an update for one with a projected -- I'm just confused as to what's our target?

DR. MILLER: A couple of things, unless someone else wants to jump in. Since I did such a good job on the last question, I've been asked to do this one as well.

In all seriousness, there's a couple of things inside your question that are fair questions. First of all, our we're doing here -- actually, is this meeting over?

MR. HACKBARTH: Go check the snow, Mark.

DR. MILLER: Should I leave? I think I need to go.

There were several things that you said that should be addressed. First of all, we're saying for the last year here when we have data the margin was 16 percent. But we know that this thing is going to happen, the 75 percent rule, which is going to have a dramatic impact on admissions going to the facility and we're just estimating as best we can, with a plus or minus kind of feel to it, what we think the margin would be. That's one set of sentences. That's what's going on on that slide, between 16 percent and 7.7 percent. So that's the first thing that's going on.

The second thing that's going on is like every other sector we put a bunch of information in front of you, quality, access, supply, volume and the margin. And I think it's really one of the reasons this commission exists, is people sit around and say on the basis of that information

and their professional judgment -- expert judgment -- what is the right thing to do in any given sector? I don't think there's any standard that if the margin is equal to X then you must do Y.

One other thing here, I think this recommendation, which does have a little feel to it of we're not quite sure, we're estimating what we think is going to happen here. I think I would characterize the recommendation as being somewhat driven by caution, that rather than zeroing it out, since we're not 100 percent sure what's going to happen here, I think we're taking a little bit more cautious approach.

MR. MULLER: Could you also say that this 7 percent estimate is at the 65 percent threshold, and when we go to 75 we'll probably knock it down a bit more.

DR. MILLER: Right, but that will be 2008 and we'll be back here making another recommendation at that point. But yet.

MR. MULLER: But going from the 60 to 65 to 75, that will keep knocking it down. So one can either anticipate that or not, depending on what your preference is, but it's still going down a little bit more.

Are the HealthSouth numbers you're correcting earlier, are they inside the 7 percent estimate?

MR. LISK: Yes, they are. And that's another reason to say those margins are potentially overstated somewhat. They do account for one-sixth of the revenue so it's kind of hard to leave them out. They probably are performing better than the other let's say freestanding for-profit facilities because of just their size and their scope but there are some issues. If you want to get into some of the details about it I can share some of those with you. But those numbers are in there, yes.

DR. REISCHAUER: Craig, did I hear you correctly that you said 7.7 percent under our best set of very uncertain estimates but if he really took the worst of all the alternatives it's 4 percent?

MR. LISK: Yes. And then make adjustments for HealthSouth and you might be down a little bit lower than that. We have really what here is a wide range and we're just giving you what we think is our best guess.

DR. REISCHAUER: But it's not minus 2.

MR. LISK: No.

DR. MILSTEIN: Following on Nancy's question and I

guess my prior point, since we're not even in the same range as the margins that we've tolerated in other provider sectors what would be the rationale in this particular case for expecting a zero productivity update in this sector? Here it's not even half, it's zero. It isn't like -- we have plenty of margin for error, it sounds like, even factoring in HealthSouth.

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

DR. MILSTEIN: That we haven't subtracted out from our recommendation.

MR. HACKBARTH: We've taken more. The draft recommendation -- and let me highlight again it's draft and this is why it's draft, so we can get perspectives on it -- is for half of the projected market basket. The projected market basket is 3.6.

So one way of looking at it is here we've taken a 1.8 percent reduction and expect them to handle that, as opposed to other sectors where the general productivity adjustment is 0.9. So this is actually a lower update, a more aggressive update.

Whether it's still too high or unfair relative to hospitals or dialysis facilities is still a legitimate

question. But it is larger than the normal productivity deduction that we take.

MR. MULLER: I think the HealthSouth numbers can really confound these estimates. Have they changed their pricing as a result of some of the issues they've had?

MR. LISK: The issue with them is that due to the accounting scandal they have not claimed fully depreciation expenses because they're having to recalculate and estimated the depreciation expenses that they have for their items. And their home office expenses are being cautious with CMS and what they claim is allowable home office expenses. So they're not necessarily claiming fully what they, in the long run, can claim for home office expenses. They're dealing again with the aftermath of the accounting scandal.

From my understanding, essentially if an employee is involved in dealing with anything with the accounting scandal, they're not counting that time as an allowable expense even though maybe 50 percent of their time or so could be considered an allowable expense in other circumstances. So that's why their costs are understated, are likely understated. It's not a payment issue though.

MR. MULLER: But the higher margins are very much

driven by what they achieved in the past and they have had to bring some of those down. Just like we had a company with outlier issues a few years ago. Once you took that out, it changed things, too.

MR. LISK: Right.

MR. DeBUSK: Before we start cutting this market basket and getting into this too deep, this industry, as I understand it, is redefining itself right now as to what qualifies for rehab, et cetera, et cetera. So you're going to have a whole shift of procedures, and maybe some new ones, and certainly a lot being eliminated from the rehab category for reimbursement.

The next two years a lot is going to shake out. So what this thing is going to look like, I think is very unpredictable. I think we ought to take a bit of caution before we do too much.

MR. HACKBARTH: It is unpredictable and we can't specifically address the relative profitability of the patients leaving under the 75 percent rule. But in a variety of ways the staff have tried to lay out conservative assumptions that would help us take at least a plausible guess at where that leads.

As Bob said, in the worst case we're talking about 4 percent after we go through this process, which compares pretty favorably to a number of other sectors.

DR. CROSSON: I understand from the presentation that we don't have data on the diagnosis-specific profitability. It seems like from the discussion, or at least the assumptions that one could make from where the industry wants this to go or not go, that there's a difference in the profitability between the diagnoses that are now on the list of 13 and those that are not. Is there some factual base for that or is that assumed from other dynamics?

MR. LISK: The only thing we can say, we don't know about the profitability. We do know that the cases that are in a noncompliant category are in lower CMG-weighted cases. The average weight of those cases being considerably lower. It's like, I think, 0.96 or something versus 1.34 for the complaint cases. There's a big difference there. But we don't know, in terms of individual profitability within those, what happens.

DR. CROSSON: Just one follow-up then. What you know, did that go into the assumption of the 16 going to

7.7?

MR. LISK: Yes.

MR. SMITH: Very briefly, Glenn. Worst case, for -- assuming making a HealthSouth adjustment to the 7.7, it is a relatively comfortable margin coming on the heels of several years of outrageously high margins.

I'm not quite sure why our bias in this case, particularly for an industry which is so weirdly distributed. This clearly is not a critical linchpin of health care providers across the United States. It is concentrated in very specific places.

So I'm just not quite sure why our bias should be toward the most conservative estimate in every case. When we do that we get to a 4 percent margin after years of 17 percent margins, rather than being more aggressive on the productivity side. We don't make a -- you suggested that half a market basket was the equivalent of a big productivity adjustment. It could simply have been a way of compensating for bad pricing in the last few years.

MR. HACKBARTH: I think both points are well taken and ideally I think we would tend to look at more than one year and where they're coming from and where they're going

to and the fact that they're geographically not evenly distributed. I think those are both good points.

DR. REISCHAUER: Some 82 or 83 percent of these are hospital-based and I was wondering if we knew anything about the PPS margins of the hospitals that have these things? Are they a random sample of hospitals? Or are these by and large the big healthy guys?

MR. LISK: I need to get back to you on that. Many of them are teaching hospitals and some aren't.

DR. REISCHAUER: That's what I thought.

MR. LISK: We do know, in terms of the impact of this rule, if we apply the impact of this on hospitals in the aggregate it's about a 0.3 percent decline in overall Medicare margin for the hospitals overall but not specifically for the hospitals that have these things. Which is about one in five hospitals have these things.

DR. REISCHAUER: When we look at other services that are embedded in the hospital, hospital-based SNFs, hospital home health, et cetera, outpatient, and we say oh good Lord, look at these big negative margins. Well it's because we can't really allocate the fixed costs correctly, maybe.

I'm wondering if that's an argument that drives down margins presumptively in other parts of our analysis, what's going on here. Is there some different dynamic?

MR. LISK: I'm actually not sure about your question.

DR. REISCHAUER: Take a hospital-based SNF. They have very low margins; right? Hugely negative margins.

MR. LISK: Yes.

DR. REISCHAUER: And we say maybe those are real or maybe the hospitals really don't allocate fixed costs correctly. But it seems to be always a reason for why it's so low. And I'm wondering well, maybe these are really 22 percent.

MR. LISK: Historically, under TEFRA, the IRF margins for the hospital-based facilities were close to zero. They did jump up with the advent of the PPS but not as much as the freestanding facilities.

DR. KAPLAN: We also did an analysis where we compared freestanding to hospital-based IRFs, exclusively IRFs, and we found that past allocation really was not an issue for this setting.

DR. KANE: To keep things going for one more

minute, on page eight this chart showing payment rates going up, after you implement a change in payment system rates go up -- it looks like 10 percent a year for a couple of years if I'm reading this right.

MR. LISK: Yes.

DR. KANE: And your costs start to go up. I guess you have to say what were you trying to accomplish with the payment system? And then maybe we can talk about the margins. Even the margins are almost the wrong focus.

This chart kind of makes me wonder what's going on? What were we trying to accomplish?

DR. KAPLAN: I think I can explain why it went up so much. In TEFRA obviously diagnosis made no difference. You were paid the same rate no matter what your case mix was. It was the facility specific limit.

When the PPS went in, they started paying on the basis of comorbidities, which of course had not been a consideration before. And that's part of the increase. Also there was coding -- which you might attribute to coding improvement.

So I think that that's a lot of why it went up, as well as the length of stay went down a little bit after the

PPS was in.

DR. KANE: But doesn't this make you think there's something you need to fix in payment system?

DR. KAPLAN: In the payment system? We actually do feel that we need to look at the payment system but that's not part of today's discussion. That's a lot of work for the future, I think.

DR. KANE: But should that take -- again, because this is my first time around, shouldn't that be taken into account in thinking about payment adequacy when you see a chart like that? Or are we just supposed to look at this margin of 7 percent and all of the uncertainty around it and think about it that way? Or maybe 4 percent.

MR. HACKBARTH: No. Good question.

MR. MULLER: There may still be higher or lower margins on that but the average acuity of the patient should go up quite a bit with going from 65 to 75. How it is after the dust settles, who knows? But clearly by going to a much higher acuity that should bring the rates down or the margins down.

DR. KANE: Doesn't it often go the other way around? Higher acuity brings higher margins? No?

DR. MILLER: Just so you don't feel like the Lone Ranger or anything, this issue has come up and does come up repeatedly in these conversations where you'll be looking at payment adequacy and trying to struggle with an update issue. People will ask regularly well, wait a minute, isn't there distributional issue here? And then we'll try to address that.

A really big obvious example that was the work that we did on revising the payment system for the inpatient hospitals that was driven by the specialty hospital, where we're saying here's the update. But by the way there's a whole bunch of underlying distributional issues here.

The only appeal I would make here is this is literally the first time we've looked at this, too. Some of the same reactions you're having, we're experiencing for the first time ourselves as well. This is the first time we've seen post-PPS information and had it to analyze here. So these are all the right questions. It's just how fast we'll be able to answer them will frustrate you, I'm sure.

MR. MULLER: I agree we're looking at this in a way we haven't before, but this is a good argument for having a good classification system in the whole post-acute

sector which we've discussed at length in other areas because we have inconsistent was in the IRFs and the LTCHs and the nursing home in terms of how to classify. So we have spoken at length in the past about having a more consistent way to classify. I think that would help these discussions if we had that. Getting there is another matter.

MR. HACKBARTH: Put up page eight, the graph that Nancy was referring to.

As we move from the left in the TEFRA period to the PPS period, how has the sector changed in terms of new entrants? Has there been a significant increase in the number of facilities or more for-profit? Or is it simply much the same over the two periods?

DR. KAPLAN: I can only answer your question today on the number of facilities. Basically the number of facilities have increased about 2 percent per year in general. So there hasn't been a huge amount of increase in that.

There has been a bit of an increase in the number of cases. So it seems that cases per facility have gone up.

We showed a 6 percent increase in case from 2002 to 2004. It was more rapid before PPS. It was 8 percent before then. So even though there wasn't a great deal of increase in facilities there was an increase in cases.

I don't have it broken down by type of facility. I can do that and bring that back to you next month.

DR. NELSON: It's on page 11, if I understood the question right. It in the handed out material. Page 11 has got the growth broken down by freestanding, proprietary and so forth.

DR. KAPLAN: Off facilities yes, but not necessarily by cases.

MR. LISK: In terms of changes in Medicare discharges on a per facility basis, it was growing actually fairly rapidly, in 2001 5.3 percent, 2002 4.2 percent, 2003 3.9 percent, and in 2003 to 2004 2 percent.

DR. KAPLAN: So more rapidly pre-PPS than post-PPS.

MR. HACKBARTH: Any others?

DR. WOLTER: It's on another point and I'm certainly no expert in the area of rehab. But as a clinician the changes in the arthritis criteria certainly

are not intuitive to me as ones that necessarily make sense.

And also, whether it's 50 percent or 60 or 75 percent that isn't intuitive to me as the best way to manage how admitting is done and not done either.

In the long gone, just to emphasize Ralph's point, I think a better patient classification system that allows us to focus on what a patient needs would serve this system a lot better than those kind of arbitrary clinical criteria.

MR. HACKBARTH: In our comment letters to CMS we've expressed reservations about the 75 percent rule and, in particular, how it was developed and implemented. So there is, I think, a lot of reason to doubt that it's the perfect way to approach this.

On the other hand, the problem that we tend to face in the post-acute area, as we have these new types of payment systems going into place that creates significant potential for people to gain. And often the new settings are higher cost than other settings where people with the same problems get treated in other communities that don't have the specialized post-acute facilities.

And as in the case of, for example long-term care hospitals, what we're trying to do in general is make sure

if we're going to pay for expensive settings that it's the right people, the people who really need it. The 75 percent rule I think is maybe an especially crude effort to accomplish that but I think that's the basic objective.

And I'm sympathetic with that. I wish we could do a better. A think ideally, as Ralph was saying, where we want to get in the long run is that we have common assessment instruments that allow us to assess where people ought to be and assess across settings performance.

DR. WOLTER: I do understand the short-term drivers. I think the point really is longer-term this isn't probably the place it will end.

MR. HACKBARTH: Any others?

Okay, thank you very much.

Long-term care hospitals.

DR. KAPLAN: This is also our first payment adequacy assessment for long-term care hospitals.

The long-term care hospital PPS began fiscal year 2003 and Medicare spending for these facilities in 2004 was $3.3 billion.

I'm going to do the same thing that I did with the IRFs. Today we're going to briefly review the factors I

presented in October and then Craig and I will present new information.

So for the factors I presented in October we found that the number of long-term care hospitals has been increasing since 1990 and the rate of increase accelerated under PPS. The number of long-term care hospitals increased 12 percent from 2003 to 2004. The volume of cases increased 21 percent during the same period. And Medicare spending increased almost 38 percent during that one year.

Beneficiaries access increased from 2001 to 2004 as the supply of long-term care hospitals, beds and beneficiaries' use increased. Long-term care hospitals appear to have access to capital, evidenced by for-profit firms being able to borrow, to repurchase their own stock, and by both for-profit and nonprofit long-term care hospitals entering the program.

Now we turn to new factors: changes in quality and payments and costs.

We find mixed results for three different types of measures for quality for long-term care hospitals. We found a small improvement in the shares of patients who died in the long-term care hospital and those readmitted to the

acute care hospital. However, these indicators are not risk adjusted.

We also investigated whether the AHRQ patient safety indicators developed for the acute care hospitals could be used for the long-term care hospitals. To calculate these PSIs, we eliminated any patients that had a PSI diagnosis in the acute care hospital. We then risk adjusted the results.

Four PSIs had results that appeared to be stable based on the number of patients and face validity: decubitis ulcer, infection due to medical care, postoperative pulmonary embolism or deep vein thrombosis, and postoperative sepsis. All four of the indicators from 2003 to 2004 increased.

However, caution is needed in interpreting these PSIs. AHRQ did not develop them for long-term care hospitals and changes in coding also could affect the results.

There is a need for better measures of quality for long-term care hospitals. In June 2004 we recommended that long-term care hospitals be defined by patient and facility criteria. Those criteria would include a standard

assessment instrument that might incorporate data to measure outcomes.

One long-term care hospital association and a large chain have independently developed quality indicators and some of these indicators are extremely similar but the measures are very different. We're encouraged that the industry is starting in this direction but greater validation of the measures is needed. Decisions on a data collection strategy also would have to be made. In addition, CMS needs to be involved in this work.

MR. LISK: Now we'll move on to examine factors that affect payments and costs per case, the last component of our update framework, and I'll present you similar stuff as you saw for IRFs.

The above graph shows how length of stay has changed since 1998. As you can see there was essentially no change in average length of stay from '98 through 2001. But in 2002 and 2003 we see fairly sizable declines of 4 percent and 4.5 percent. In 2004, however, we saw a slight uptick in length of stay.

What does this mean for payments and costs?

This next chart on your screen shows a cumulative

change in payments and costs from 1998 through 2004. As you can see during TEFRA, the left part of the graph, payments and costs grew together. But after implementation of the long-term care hospital PPS, the right part the graph, we saw a rapid growth in payments in both 2003 and 2004 of 5.5 percent and 13.2 percent respectively.

If we look across, however, the first year of the PPS brought essentially no change in costs per case. In 2004 costs per case climbed almost 9 percent, possibly in response to the large increases in payments they received after the implementation of the prospective payment system.

So what does this all mean for the margin?

As you can see in this overhead, margins for long-term care hospitals were near or just below zero in the aggregate under TEFRA. Under the long-term care hospital PPS Medicare margins have increased rapidly, to more than 5 percent in 2003 and 9 percent in 2004.

Examining the distribution of margins for 2004 we find that 23 percent of long-term hospitals had negative margins. We find that in 2004 for-profit facilities and hospitals within hospitals had the highest margins and government hospitals had the lowest.

Finally, we see a rather wide distribution in performance under Medicare, with more than a quarter of all hospitals having Medicare margins exceeding 17 percent.

DR. KAPLAN: Before we talk about modeling the 2006 margins, I want to remind you about the 25 percent rule for hospitals within hospitals. We've discussed the 25/75 and that type of thing,

there

When the policy phases in hospitals within hospitals will be limited in the share of cases they can admit from their host hospitals. The phase-in begins this fiscal year.

Hospitals within hospitals have higher margins than freestanding long-term care hospitals in 2004. Despite our desire to model the effect of the 25 percent rule when modeling 2006 margins, we are unable to do that at this time.

For purposes of projecting the 2006 margins we modeled the changes on the screen. In 2005 long-term care hospitals received a market basket increase adjusted for budget neutrality for an update of 2.6 percent.

In 2006 several changes affected long-term care

hospitals' payments. First there was a market basket increase of 3.4 percent. At the same time, the outlier threshold decreased and payments increased. Finally, when the inpatient PPS changed the case mix groups, LTC-DRGs -- the case mix groups -- also changed and the relative weights changed, resulting in a decrease in payments. When we modeled the estimated 2006 margin, the result was 7.8 percent.

Our findings suggest that long-term care hospitals are more than adequate based on an increase in beneficiaries' access to long-term care hospital care, a very rapid increase in supply of long-term care hospitals, and even faster increase in volume of services and spending.

A mixed picture on quality but one that does not suggest anything about the level of payment, that LTCHs appear to have adequate access to capital and a Medicare margin of almost 8 percent.

This is the first time we're recommending an update for long-term care hospitals. The draft recommendation is that Congress should eliminate the update to payment rates for long-term care hospital services for rate year 2007.

We welcome your questions and comments.

MR. HACKBARTH: Go ahead, Nancy.

DR. KANE: I'm not even going to say it because I know you know.

DR. REISCHAUER: 7.7 is different from eight.

DR. KANE: You know what I'm thinking.

MR. HACKBARTH: Actually, I think there's a Journal article in the making here on when PPS works and when it doesn't.

This was an era where we decided prospective payment worked for hospitals, created incentives that helped reduce length of stay. So we've got a hammer. Everything is a nail. We're just going to start whacking everything, even if we don't have the prerequisites like a good case mix tool or definitions of who needs services, we're just going to create a PPS. It doesn't always lead to better results than cost reimbursement with limits, at least from a financial standpoint.

DR. REISCHAUER: I look at these numbers and they infuse humility in your analytical abilities because LTCH were churning along in the late 1990s and early 2000s with negative margins, slightly negative margins on Medicare. 73

percent of their business is Medicare, so they're largely a Medicare kind of outfit. The number of them growing rapidly and the number of for-profit ones are growing rapidly. And they're freestanding too, so it can't be some kind of hospital kind of shifting of costs.

You wonder what's wrong with all the economics training I got, that suggested that markets where people are losing money, the number of institutions should begin to contract. How do we explain this?

DR. KAPLAN: Go ahead.

MR. LISK: Some of it is under TEFRA how you come under the system. And it may be in anticipation that they were going to be going under a PPS in the future, at some time in the future. So under TEFRA, when you first come in, you're paid on cost for the first -- was it two years, I believe -- to establish your TEFRA limit.

DR. REISCHAUER: But they had negative margins.

MR. LISK: The other thing that happened too, is in BBA --

DR. REISCHAUER: So the prospect of losing money forever is what attracts them?

MR. LISK: Also, the BBA, I believe, put in some

limits that put a cap on the TEFRA rate at the 75th percentile.

DR. KAPLAN: The BBA made a big difference.

MR. LISK: So it did have an impact on lowering some of the hospitals' margins. There's distribution there that is underlying this, too.

DR. KAPLAN: This is an aggregate margin.

DR. SCANLON: The issue is you can't just take economics courses. You have to take accounting courses, too.

[Laughter.]

DR. SCANLON: We've seen this with other PPSs as they've gone into place. That all the costs don't turn out to be costs because when you're operating under a cost-based system you may have related party transactions which have a profit in one of your cost items, you may have sort of capital expenses which turn out to be much higher on the accounting side than they are on the real side. And so it turns out to be very profitable to operate at a negative margin.

MR. DeBUSK: [off microphone.] Those are not real dollars on the other side.

DR. SCANLON: Not necessarily.

DR. REISCHAUER: John is going to say we have to be an actuary, too.

MR. BERTKO: No. The actuary in me is looking back to your slide two and the 21 percent number there. Which if I'm reading that correct, is that a one year increase in the number of cases?

Alan and I were just looking at this is a very large number. So one can only say that it is pulling cases out of some other facility. Do we have an idea which wants and why they're being pulled out, other than the money?

DR. KAPLAN: No, we don't know that at this point as to where they're coming from. We did an analysis that we reported in June 2004 and we really didn't look at where they had been taking patients from.

MR. MULLER: You could be in a hospital-based SNF at minus 17 percent or you can an LTCH at plus 20.

MR. HACKBARTH: Didn't you show us a map last time, or actually a series of maps, that says here's the number and in such-and-such a year, and it just sort of grew?

DR. KAPLAN: I'll be happy to bring that series of

maps back in January.

MR. HACKBARTH: Part of it is the proliferation of LTCHs and geographic spread. It's still limited but it's spread to new geographic areas. But they were cared for in SNFs.

DR. MILLER: To the two points, it's important to remember that this was relatively a small base. For Medicare terms relatively small base, probably any other room it would be a large one. So we're talking about increases in facilities in cases off of a small base and growing pretty rapidly.

And then to the point of where they're coming from, and I'm going to not speculate here but just extrapolate a little bit. When we did the long-term care report a year or a year-and-a-half ago, we found once you controlled for various things that the substitutes in the markets where these existed were that SNF and the hospital.

So to the extent that we have notionally an answer, that's where we think these are coming from. I wouldn't necessarily say this is it, but that is notionally what we were finding about a year ago or so.

MR. BERTKO: So the question I would have is if

they come out of the hospital, as Alan and I were just talking in a sidebar, that that is probably a cost reduction. If they come out of a SNF you might get a quality increase but you also get a cost increase maybe? I'm curious.

MR. HACKBARTH: It depends on the exact circumstances if they come out of the hospital. They were in the hospital, we're paying a fixed amount per case. If, in fact, they are outliers --

DR. KAPLAN: What we found was that -- I can't remember what we found on the outliers. I only remember hospitals within hospitals versus freestanding.

Basically what we found is that if long-term care hospitals were allowed to admit every type of patient then it costs Medicare money. This was pre-PPS.

But if they admitted people who the sickest and who appeared to need this type of care the most, then it was more money but it was not statistically significant. That's basically what we found. But we haven't done it since the PPS.

MR. HACKBARTH: That was the foundation for our recommendation that we need patient and institutional

criteria to define who should be eligible for this care.

Other questions or comments on LTCHs?

DR. REISCHAUER: Haven't hospital-based SNFs been closing?

DR. KAPLAN: Yes.

DR. REISCHAUER: I was just wondering whether --

DR. KAPLAN: About a third of them have closed.

DR. REISCHAUER: 27 of the 38 LTCHs that came into existence in 2003 to 2004 were hospital-based. I wonder if hospital-based SNFs are being converted into LTCHs because of a more favorable payment standard?

MR. MILLER: [off microphone] Jennie, this is one of yours.

[Laughter.]

MR. HACKBARTH: Any others?

Thank you very much.

Next is skilled nursing facilities.

MS. LINEHAN: She's not sitting up here, but I want to first acknowledge Carol Carter's work on some of the quality section in this chapter, and I might be turning around to ask her a question.

In our March report, we'll be making an update

recommendation for skilled nursing facilities for 2007.

CBO estimates that Medicare spending on SNF services will be $17.8 billion in 2007. The average annual growth in spending is expected to be 3.5 percent between 2004 and 2015.

Last time I talked about supply, volume, access and quality in this sector. This time I'm going to discuss access to capital and payments and costs before I review briefly the factors that I presented in October. And then I'm going to discuss some of our recommendations for improving quality measurement in this area.

Access to capital for SNF varies by the type of control of the nursing home, whether the facility is part of a larger organization. I should also note that when we discuss access to capital for SNFs, we're actually talking about the nursing facility, because most SNF care is delivered in a nursing facility that also provides long term care.

Large publicly traded companies that offer skilled nursing facilities saw their stock values increase over the past year and several chains reported facility construction and renovation. An analyst we spoke to about this sector

said that investors see untapped value in nursing facilities and have purchased or expressed interest in purchasing nursing homes. And also said that CMS's RUG refinements announced this year removed an element of considerable uncertainty from the payment environment for SNFs.

Large chains regard Medicare payments favorably and continue to seek to increase the Medicare share of patients to improve their overall financial performance.

The not-for-profit SNFs appear to face more limited access to capital, although data on the demand for access to capital is generally less available for not-for-profits. Analysts continue to have a negative outlook for the non-profit SNF sector. Annual public debt issuance for non-profits dropped again in 2004 to $368 million, and it's expected there won't be many investment grade nursing homes.

Nursing homes may access capital through mortgages and other loans relatively cheaply, as interest rates remain low, but we don't know the extent to which this type of borrowing is happening.

It's also worth noting that to the extent that we assess access to capital to determine what the Medicare payment update should be, it's worth noting that there are

other government programs that exist to insure mortgages for nursing facilities and assisted living facilities. Through HUD facilities can obtain insured mortgages for construction and renovation of facilities. In fiscal year 2004, HUD insured mortgages totaling $1.5 billion for nursing facilities and assisted living facilities, but most of that is for nursing facilities.

Now moving on to our margin discussion. In fiscal year 2004 Medicare margins for all freestanding SNFs, which are about 90 percent of SNFs or 13.5 percent, the margin for hospital-based SNFs continues to be drastically negative. It was negative 85.8 in 2004.

We see some variation by facility type but even among freestanding facilities we see variation. Margin for rural facilities continued to be higher than those for urban facilities. This difference has persisted since the beginning of the PPS.

Based on 2004 cost report data we estimate that the 2006 aggregate Medicare margins for SNFs is 9.7 percent. This reduction from the base year is a function of a combination of payment changes that will be effective in 2006 including a full market basket, RUG refinements and the

elimination of the add-ons. The combined effect of these changes is estimated to be a 0.1 percent increase across the industry and a negative 0.4 percent increase for freestanding SNFs. Hospital-based SNFs are actually expected to see bigger payment increases due to these changes.

As I said, we find differences in margins between facilities based on facility characteristics, and I'm going to talk about one of those differences which is the difference between the margins of proprietary and voluntary facilities.

Although the estimated overall SNF sector margin is adequate to cover the costs of providing care to Medicare patients these differences in margin by facility type mean that as the margins are projected to decline in 2006 certain categories of providers -- government facilities and voluntary facilities -- margins are approaching zero.

We looked at differences between proprietary and voluntary facilities for evidence of what may be driving the differences in these margins and I wish I had something conclusive to tell you. But we did find that in 2004 voluntary facilities had an aggregate higher cost per day

than proprietary facilities. And then we looked at the cost growth differences between 2000 and 2004. Costs per day started out higher in voluntary facilities, grew at a higher rate, so the differences have persisted over time.

We also found differences in the average MDS short stay quality measures by ownership type, but these measures aren't risk adjusted so differences could be reflecting the severity of patients. In the absence of good quality measures for SNFs we can't determine whether cost differences were actually related to quality differences.

We didn't find evidence of difference in case mix, as measured by the share of days in the RUG categories. However, facilities could vary on patient characteristics that may affect cost, such as the use of costly prescription medications, but aren't captured by the RUGs.

And finally, facilities may have different cost structures. For example, voluntary facilities may have higher nursing or overhead costs.

Regardless of whether the differences in the margin by type of facility characteristic characteristics reflect differences in efficiency, patient characteristics or both, we do know that the payment system does not target

payments based on patient resource needs and that RUG refinements did not address the problems with the payment system, and that the payment system is currently based on outdated case-mix weights.

We plan to investigate alternative ways to improve the payment system to pay all providers for the provision of SNF care. And we also see from this that case mix adjusted quality measures are critical to ascertaining what we're getting in facilities with divergent costs.

Now I'll quickly review what was in the chapter and what I presented in October.

The overall supply providers remained stable in 2006 with the share of freestanding SNFs continuing to grow and the share of hospital-based SNFs continuing to decline. Volume is measured by total days, total payments. And total stays increased in 2003, the latest year for which we have data.

And increased use, even with the loss of some payment add-ons, suggests continued access for Medicare beneficiaries.

We continue to have limited measures of SNF quality. Two of the MDS-derived measures we have show no

change in quality and one shows some improvement.

As I just mentioned a minute ago, access to capital appears good for for-profits, less information on not-for-profits, and the margin in 2004 is 13.5 percent and is expected to decline in 2006.

So, as we've been doing in all other sectors to start our discussion, last year we recommended no update for SNFs and that's the recommendation you see on the screen.

SNFs received a full market basket update in 2006 but that, combined with other payment changes, resulted in a net update of, as I said, before 0.1 percent. Current law calls for a full market basket update in 2007 and that's estimated to be 3.4 percent.

Now I'll review the Commission's long-standing concerns about the distribution of SNF payments. We think this is an important discussion to have in this context because although the overall payment levels appear adequate, payments are likely not targeted to patients' resource uses.

The payment system was refined but CMS has acknowledged in their final rule that work in continuing to refine the payment system is still needed.

We've had basically three criticisms of the

payment system since its inception. It's related to the payment for non-therapy ancillary costs, the payment for rehabilitation services based on the actual or estimated amount of therapy provided rather than some kind of predictor of the need for therapy, and the payment rates are based on relative weights that are old and are expensive and time consuming to update.

This leads us to our second recommendation which is to adopt a new classification system for care in the skilled nursing facilities.

The implications of this would be no spending implications but would lead to better accuracy and improved equity among providers.

Finally I'm going to move on to discuss some of what we discussed in the draft chapter about the need to improve quality in this sector, quality measurement.

In light of the limited set of currently used SNF quality measures, we continue to investigate avenues for measuring SNF quality and ways to improve the data to assess SNF quality. Recall that the three MDS-based measures that are currently the only publicly reported SNF quality measures are limited for several reasons. They're not

collected at admission and discharge. One of the measures, pressure ulcers, was not found to be valid in repeated studies, and they don't capture the most important dimension of SNF care or tell whether patients has benefitted from their care.

CMS has tested and validated additional short stay measures but these sort of suffer from the same problems. We don't have measures for patients who don't have a 14-day assessment, which is about half of the SNF patients.

CMS has added one process measure of flu and pneumonia immunization rates in nursing facilities, but we still have a fairly limited set. So last year we recommend additional ways to improve quality measurement for SNFs, including assessing functional status at admission and discharge from the SNF for all patients.

We also discussed additional measures, rehospitalization and discharge to the community, that have been developed by researchers to assess important dimensions of SNF care. These measures could be calculated from existing data but are not currently part of any publicly available data produced by CMS.

Because of the limited set of SNF measures, we

continued this year to review literature and interview experts about additional avenues for developing SNF-specific quality measures. As in another settings, we found that process measures could be used to assess quality in the SNF setting. Outcome measures are the gold standard quality measures but process measures can complement outcomes because they help providers identify steps to improve care. Process measures also assess care that is completely under the control of the provider.

We reviewed literature on guidelines applicable to aspects of SNF care and experts told us that process measures were viable in the SNF setting because there are important care processes that should be followed in the SNF. These guidelines could potentially be adapted as process measures of quality. Some of these guidelines, such as pressure ulcer prevention and pain management, apply broadly to all SNF patients. Others, such as glucose monitoring for diabetic patients, are relative to patients with specific diagnoses.

Additional work to assess the strength of the clinical evidence around and the level of consensus for process measures is needed. An additional challenge to

developing process measures is related to data collection. Claims data and the MDS with modifications could be used to develop some measures but others would likely require new data collection efforts, for example to know whether a patient has received particular medications. In addition, diagnosis coding would need to be improved to determine diagnosis specific measures.

We're reiterating our recommendation last year and adding that we think that process measures should be included in any SNF-related quality measures that are developed.

That concludes my presentation. I'll take your questions.

MR. HACKBARTH: Questions?

MS. HANSEN: Just going back, first of all, to the profitability of the voluntary and government nursing homes vis-a-vis the for-profit sector, is there a description of the relative percentage of some of those facilities also serving Medicaid populations, as well? I know this is Medicare only, but whether or not that has impact at all in terms of spreading some of the expenses due to the Medicaid reimbursement.

MS. LINEHAN: I can't directly address the Medicaid question but we did look at differences in Medicare share. It was share of days. We didn't find big differences in aggregate in the voluntary and proprietary facilities. I think it was 10 percent for the voluntary and 13 percent for proprietary. That was a surprise to me.

I can't directly address the Medicaid question but that's definitely something that could also be related to this that I didn't mention.

MS. HANSEN: Part of just hits me because I'm so accustomed to Medicaid facilities. And oftentimes the voluntary and the governmental sector end up having a higher proportion of that. Given the kind of reimbursement that occurs, it's the cost reporting as to what gets reported on the Medicare side as to how they spread that.

But I just wonder whether that potentially colors the kind of reporting that comes out of this when other hospitals can kind of pretty well be more exclusive to a Medicare population only. That's the source of that.

The other thing, this is my first year also but I really do concur with your third recommendation, even though this is a reupping again, to make that recommendation on

quality measures. That seems to be absolutely crucial in terms of now maybe with the new RUGs, whether that helps at all.

But the kind of measures to measure quality in a Medicare stay just really needs to be examined. I think it's put forth here. But however we can continue to put some muscle behind that, I really would support.

DR. SCANLON: I think this is a great summary of the issues with respect to SNFs.

I have one comment about draft recommendation two, and it's the third bullet about a new system based on data that are easier and less expensive to update.

CMS did have a contract in terms of the revision of the RUG system and that was actually, I think, one of the questions that was being considered. I think that while this would be potentially a wonderful ideal to have, it's not clear that there's a ready solution that's going to do this. I think that it's perhaps more important to say bite the bullet and collect the data to update the system and make that recommendation. And maybe in the text say think about how you can do this on an ongoing basis.

But to let a system that's almost been in place --

or soon it's going to be in place 10 years -- to have it based on data that become so old, and we recognized from day one about how thin they were in terms of different types of residents. It just becomes unconscionable, given the amount of money were spending here.

So I think we've got to make the investment, we should be making the investment, to have the right data, even though we know it's expensive to do.

MR. HACKBARTH: Would you propose, Bill, to drop the last bullet from the recommendation and put it in the text?

DR. SCANLON: I would propose that it be based on more current data or make part of the recommendation to make the investment to collect the data to update the system.

MS. LINEHAN: CMS is actually redoing a time study. It's in the works and they're planning on doing it next year.

You're right. I mean, this is more of an ideal. I think what we're thinking for the future is this would be one of the dimensions that we would use to evaluate alternatives.

DR. SCANLON: Okay.

DR. MILLER: I want to pick up because I see your point. But I also want to make sure that the significance of what we're talking about with recommendation two isn't missed. Of course, I want to be sure I'm right here.

The comment you're referring to refers to the information that would be used to support RUGS; is that right? That's fair and we can change it and we can discuss it in the text. So no problem there.

I just want to be sure all the commissioners and everyone else understands what when we talk about this we're saying it could be something different than RUGs, too, when we say adopt a new classification system. It could be RUGs. It could be something altogether different or some more significant modification of RUGs.

But that doesn't change your comment. I just want to make sure that everybody understood the depth of what we were talking about here.

DR. SCANLON: I do think that the CMS contract did, in some respects, have an open mandate to consider alternatives. But we were kind of back in the current mode, because it's not clear that there is something that's right out there that you can pick up on.

MR. MULLER: With the big difference between the -- I think the total margins is 13 and the hospital-based -- I think you said something like minus 80. But it's minus 20. It's a big difference. And especially in light of the conversation a few minutes ago about the LTCHs and so forth.

Do we have any policy vehicle for looking at updates on or payment on the hospital-based different than the total? Because obviously when we have something at minus 20, minus 30, minus 80, that's something we should be looking at in terms of adequacy. If it has policy consequences that -- we were speculating loosely earlier that some of this may be some of the reason for the LTCH growth. But that would have been unreasonable assumption, given the kind of differences in the margin.

So do we have any policy vehicles to address that?

MS. LINEHAN: What I was going to say is you did recommend a differential update at one point.

MR. HACKBARTH: I think that was three years ago.

MS. LINEHAN: I don't know if that's what you're talking about, but you did it before.

DR, REISCHAUER: I think the first question you want to answer is is there a reason to keep these alive if

under an efficient payment mechanism they can't hack it? We did go through analyses that seemed to show that their patients weren't a whole lot different in the areas where hospital-based SNFs existed other facilities of one kind or another were capable of handling these patients.

So I think we'd have to justify the need for this as a particular setting for that institution before we could justify an additional payment.

MR. MULLER: But you also have to look at it within the spectrum of care. So if you're paying more in an LTCH than in a hospital-based SNF, you would want to make that kind of opportunity argument, wouldn't you?

DR. REISCHAUER: Now you're admitting guilt on the last session.

MR. MULLER: I'm not admitting guilt.

[Laughter.]

DR. WOLTER: Just on Bob's point. And of course this is anecdotal, but we maintain a SNF in our hospital and we believe the patients are different. In the freestanding SNFs in our community we are being told by those nursing homes please do not close your SNF because we can't take care of those patients. Our physicians believe that there

is a group of patients who just aren't ready to go out to a freestanding SNF.

When Sally and I and others did the LTCH visits whenever that was, last year or the year before, we heard from some of the physician at the LTCHs that there was nowhere else to send these patients now that the hospital-based SNFs had closed because they didn't consider the freestanding SNFs really capable.

So I don't know that we have the answer on that particular point yet. My experience though tells me there is something different. Of course, we're moving in a right recommendation by recommending a new classification system. The problem is as the years unfold, it's never happened.

MR. HACKBARTH: Now that I think back on the history, I think actually we recommended a differential update maybe two years in a row. That was premised on the hunch that, in fact, the patients were different. And then we did a little bit of research and looking around to see if, in fact, we could verify that hunch in any analytic way. And we came up with short in being able to back that up, is my recollection.

DR. MILLER: That's my recollection as well, and

anybody on the staff who can remember this better should speak up.

But there was another layer to it that we had some other work done. There was a really interesting finding in that that even further complicates the point. If you look at the distribution of patients who go to a hospital-based SNF versus a freestanding SNF, what you find is that there's a very stark sorting of patients between them. And the ones who go to hospital-based SNFs tend to be younger. They tend to have a spouse available to them. They tend to be more -- they have rejected do-not-resuscitate orders, that type of thing. It's stuff that's not captured by the case mix, but clearly a sorting process that goes on between the hospital-based and the SNFs. So these are people who are more likely to have a short stay and get out and be --

MR. HACKBARTH: Now was in the context of trying to compare the different settings for -- was it knee and hip patients?

DR. MILLER: No, this was something even further back.

MS. THOMAS: We were just doing a comparison of the characteristics of patients who go to hospital-based

SNFs versus free-standing.

DR. MILLER: I also wanted to say one other thing about a vehicle. You were using the word policy vehicle -- and I want to make sure I get this right, Sally. We also have another analysis coming on deck for the spring cycle that's going out into the marketplaces. We're trying to pick marketplaces where hospital-based SNFs have kind of hung around, gone in large numbers, that kind of thing, and trying to figure out whether there are structural differences on what drives those changes.

So we're going to try another pass at this. That's more of an analytical vehicle, as opposed to a policy vehicle, which I wasn't quite sure what you were --

MR. MULLER: Obviously payment differential is a policy vehicle as well.

But if, in fact, they are an extension of the hospital population, for the reasons that Nick suggested, very acute but not as acute as your average hospital patient. So in that sense it becomes standard. But if the payment rate is so much less within a cost structure that looks more like a hospital structure, you expect pretty high negative margins.

And since the LTCHs have the 25-day minimum and so forth and by what Mark is saying -- I don't remember these numbers -- what the average length of stay is in hospital SNFs. So it may be -- it's shorter.

So they just may be people transitioning out of the hospital to other settings, including maybe freestanding in due time.

I'm just suggesting that if we're -- at very high negative margins they're going to keep closing, and whether that's the right place to be, even granting Bob's point. They may be too expensive vis-a-vis -- they're more expensive than they're currently getting. But they may be less expensive to run them than either backing up the hospital if you don't have alternatives. They probably wouldn't go into LTCHs with the 25-day limit.

MR. HACKBARTH: Another additional complication in this picture, as some people around the table have reminded us from time to time, the capabilities of a SNF are not fixed and they vary from community to community, in part dependant on what other kind of resources exist in that community.

So we talk about these labels as though they're

really defined, well-defined units with very predictable capabilities. And that isn't always the case either. It is a very complicated area.

Other questions for Kathryn, or comments?

MS. DePARLE: I was toying with what you said, Glenn, and thinking that what we're really describing here, from what Nick said anecdotally to what Ralph and others have said, and what we've talked about for the last several years and the reason why we made the differential update recommendation, is we have a hunch that clinically this is a level of care that is needed for certain beneficiaries. And it appears that in some communities it's occurring in hospitals and in some communities it's occurring in freestanding SNFs. In some communities it may be in an LTCH bed, and maybe even in home health in some communities.

And so is there some way, this goes back to our long-standing recommendation that what should be happening here is sort of a post-acute care, post-acute assessment and more of a -- in each community, however you would define that, there should be that level of clinical care available for a patient who is assessed to need it. But it doesn't necessarily have to be in every hospital.

That said, I'm very troubled, as I'm sure everyone else is, by data that would suggest that we have hospitals trying to do this with 85 percent negative margins. I just don't see how we can do that.

So I, at least, would be in favor of having a separate update or a differential update for the hospital-based facilities. It's not perfect. It's not where the system should be. But in the absence of anything more comprehensive that would begin to solve this a better way, I'm just very troubled by not acknowledging that and setting it fourth. Because I do think people look at our reports and would get from that that we're concerned about the existence of this service in some communities.

Maybe you think we have enough information to do that. I don't know.

DR. REISCHAUER: But if we went just by the numbers, what we'd recommend is no update except for hospital-based. And in hospital-based a 90 percent update. And that would get them up to a 5 percent margin or something.

I ask you how our credibility would look with that recommendation versus the one we were considering?

MR. SMITH: I supported the differential update that Nancy-Ann is suggesting both times that we did it. It seemed, to me, to make sense because we did suspect that they were either in a different line of business or treating a different group of beneficiaries. Neither of those assumptions appears to be true.

But what may matter a lot, and we don't know enough at this point, but maybe we'd need a plan to find it out. What may matter a lot is context and what the marketplace for providing post-acute care looks like in a place that does or doesn't have a hospital-based SNF? Or what are the characteristics of the rest of the marketplace that cause a hospital to shut one down, as opposed to a decision by a differently situated hospital to keep one open?

I think before we can return to making a differential update recommendation we need to try to figure out more about what we're trying to preserve and protect here. There's little evidence that we're trying to preserve a different line of work. But there may be some evidence, we think but we're not sure, that we may be trying to preserve access to a certain kind of post-acute care in a

marketplace that doesn't offer up a sufficiently rich mix of alternatives.

I'd like to see if we can't figure out how to do that before, as Bob says, we say something: A, that we've said twice before and it didn't make much difference. Hospital-based SNFs continued to close rapidly and at the data suggest continued to operate at very large negative margins; and doing it again without having a more compelling reason than we have. Our credibility, such as it is, would probably be impaired. But also. we wouldn't be able to figure out how to talk about it. We couldn't write about it because we wouldn't know how to make sense out of it.

DR. MILLER: We do have this study to go out and look, I think it gets at it a little bit of what you were talking about.

Just one other idea that we just talked about at the staff level and sort of have it churning around is whether you start thinking about moving away from a per diem here and start thinking about more of an episode-based payment. But this is just talk at this point. We're still looking at a whole range of ideas here.

DR. SCANLON: I was going to add, in terms of

looking at this, I think it also would be important to look at the hospital stays of these two groups of people, those that end up in a hospital-based SNF versus those that end up in freestanding, to be sure that they are comparable in terms of the type of services being received and the length of time that they're there. Because that's a piece of this, as well.

Especially if you take -- Mark's mentioning episode, look at the overall episode not just the post-acute episode.

MS. DePARLE: And readmissions as well, I think.

MR. SMITH: The other thing that might be useful, we might learn something about the distribution of the negative margins. Do they vary in any significant way depending on context? And the alternatives available in that local marketplace.

And are there some hospital-based SNFs that don't have very sharp negative margins? And if so, what can we learn that would explain them?

MR. HACKBARTH: We look at the departures as potentially an indicator of a problem. That implicitly assumes that the starting point was the right level. I

remember when Jack Rowe served on the Commission several years ago when we were talking about this. He said maybe the starting point is not right, that people went into this line of business to take advantage of opportunities to shorten inpatient stay and maximize their payment pre-transfer policy rules.

And so you would expect some natural readjustment of supply as those issues have been addressed. So maybe we're going down towards the right level of supply of hospital-based SNFs and we shouldn't be fretting about departures.

DR. MILLER: That reminds me, and I forgot this point. At the time we were having that discussion there was also -- I think I'll get this wrong. But isn't there like a three-year period where you kind of got cost reimbursement to set your base, and then they rolled into PPS?

There was some arrangement like that, as I recall, pre-PPS.

MS. LINEHAN: You did some work a few years ago where you looked at the characteristics of hospital-based SNFs that left. And I can't remember the array of characteristics. But they were more likely to be recent

entrants into the market. They were more likely to be for-profit. There were a couple of other things.

DR. WOLTER: I was just going to say that I do think, kind of to Bob's comment, you wouldn't probably go to a 90 percent recommendation update for a lot of reasons. But one of them is that there still is some financial value in having that setting in a hospital, even with the transfer rule coming into play. There's still some value for patients who might otherwise go on the long side of length of stay. I think people put that into they're analysis when they make the decision as to whether or not to stay with a hospital-based SNF. So it's probably important to make that point.

Having said that, I'm quite confident that in some communities the patients that are being care for there are patients who do have a little different profile than those who would go out into the freestanding SNFs. I wish we could get data that would show that.

MR. DeBUSK: Is that called the LTCH?

MR. HACKBARTH: Any others?

Okay, thank you, Kathryn.

Next, Sharon is going to present on home health.

MS. CHENG: Okay, last payment adequacy presentation of the day

In the next couple of minutes that I have with you, I'll fill in the parts of the framework for home health services that we began to discuss at our last meeting. Today I'll have geographic access, changes in the volume of service, financial performance, and changes in the rate of growth in the cost of producing an episode of home health.

The first piece of the framework that I have for you today is access. We have two questions that we typically here. One is do communities have providers? And then are beneficiaries getting care?

Last month we looked at whether or not beneficiaries had problems accessing care. We used the CAHPS survey for that and we found that 90 percent of beneficiaries reported little or no difficulty getting care. This month, thanks to some terrific work by Sarah Kwon, we have a look at geographic access. What we're asking here is do communities have providers that are willing to serve the beneficiaries there?

The bright yellow that covers most of the map is the color code for a zip code that was served by two or more

home health agencies in the past 12 months. The orangey-red color are areas that were served by one home health agency in the last 12 months. So it's the light blue areas within the map that were not served by any home health agency in the past 12 months.

Although some of the light blue areas cover quite a few square miles, they are very sparsely populated. 99 percent of all beneficiaries live in yellow or orange areas on this map.

This zip code analysis is one that I've brought you before and I've got to share the caveats to it. The fact that a home health agency served a beneficiary in one corner of a zip code does not necessarily suggest that the home health agency would be willing to serve all of a zip code that might be very large or might be geographically diverse.

On the other hand, for some of the very sparsely populated areas, if no beneficiary in that community sought care within our window, then there would be no service recorded even though there might be a home health agency that's willing to serve that community.

You can see that many of the red areas are in

rural areas. As you recall, we did use CAHPS again to see if there were differences in the access reported by beneficiaries living in rural and urban areas. What we found actually was that rural beneficiaries reported better access to care than their urban counterparts. I only mention this to suggest that living in a red area on this map is not necessarily indicative of access problems for home health.

I think when we look at this map overall, what it does suggest is that almost all urban and rural communities have a home health agency, at least one, and many have two or more.

The second piece of the framework that I have for you is some information on the two most recent years of the volume of home health services. We have a couple of different ways we think about this. We look at the number of users. That's increased from 2003 to 2004. The number of 60-day episodes that are provided to those beneficiaries also increased. As you could see, the relationship between those two numbers has changed a bit. So we go from an average of 1.6 episodes per user to 1.7 episodes per user.

What this suggests is that home health agencies

are providing a second or subsequent episode to beneficiaries more frequently in 2004 than they did in 2003. This is the continuation of a trend that's been continuing. There were 1.5 episodes per beneficiary just three years ago into 2001.

The number of visits per episode, which is another way we think about the volume of services, remained unchanged between 2003 and 2004.

As the number of visits per episode held steady, the quality of outcomes that are produced in those episodes stayed the same or improved. This is something we went into in more detail last month. Just to touch on it, indicators of improvement in functioning -- ability to walk, to bathe, to dress -- continue to show slight improvement. Indicators of the use of hospital or ER services have remained unchanged.

The next part of the framework that we have is information on the financial performance of home health agencies. And our base year for this data is 2004. So on the screen I have the number of HHA's, freestanding home health agencies, in our sample and then the margin by group. The overall margin for aggregate home health agencies is 16

percent. And then I've broken it down by some groups that you've seen in the past.

I characterize the agencies by their caseload rather than their location, so urban agencies serve that population. A mixed agency tends to serve 60 or 70 percent rural beneficiaries and the rest are urban. Then rural agencies are serving purely rural beneficiaries.

We also look at the type of control, voluntary, private, or government controlled agencies. I've also broken it down by size. Again, the way I think of size here is I take the number of episodes that the agency provided in a year and then I've broken that into quintiles. So the very small agencies, the first to 20th quintile there, ranging to the largest agencies, the 81st to 100th quintile.

The patterns that we see here in the relative margins are very similar to patterns that we have seen in the past several years when we compare these groups.

So starting then from 2004, I also go through the exercise of looking forward and seeing if we can get to 2006. So I take the changes that have occurred in the payments into consideration. The first change was the update of 2.3 percent that they had to their base payment in

January 2005. In that year there was also an increase in the pay out of outlier payments. Then in April of 2005 the rural add-on expired.

In January of 2006 they will receive an update to their base payment of 2.8 percent, and they will also begin a transition to a new definition of metropolitan areas. This transition to the new Metro areas will be budget neutral once it is applied to all home health agencies. We include it in our thinking because it has the effect of raising the base payment for rural agencies slightly more than average and for urban agencies slightly less than average.

The change to the new metropolitan areas will be phased in over the next two years to smooth some of the volatility in the wage index.

In addition then to looking at the changes in payments between 2004 and 2006, we gather information about the changes that are likely to occur in the costs. What we've seen here is that since the first full year of the PPS, that was 2001, the increase in the cost of producing an episode of home health has changed very little. There has been an average annual cost growth of 0.6 of 1 percent.

But again the theme that we have in home health is that everything varies. So within this widely varied industry, we have widely varied cost growth. For example, one-quarter of all agencies over this same time period had an average annual cost growth of 3.4 percent. Another quarter of home health agencies saw their costs actually decline at an average annual rate of 0.7 percent.

We looked at some of the other variations in cost growth. Generally government agencies had the greatest rate of cost growth, voluntary agencies somewhat less than that, and private agencies actually generally saw declines. Cost growth did not appear to be related to the size of the agency. In each case, every time we grouped these agencies together, there's more variation within the group than there tends to be among the groups.

Our model here, as in elsewhere, brings the changes in costs and the changes in payments together as we look forward. So given the high margins in 2004, the impact of the positive updates and other payment changes that have occurred, and the very slow historic cost growth, we would project that the margins for this sector would rise slightly into 2006 to a 16.9 percent margin.

To sum up, bringing all these factors together then, we have seen access both ways that we think about it to be generally good. We do see that most communities have providers. We observed last month that providers are entering this sector rapidly. There's been 500 entrants over the past 12 months and there have been about 1,000 entrants over the past couple of years.

Quality continues to improve slightly. Volume of services is increasing. The current margin that we measure is 16.0 and we project the margin to rise to 16.9. Part of that reflects historic slow cost growth in the per episode costs.

All of these factors together tend to suggest that agencies should be able to accommodate cost increases over the coming year without an increase in the base payment.

In current law, if Congress does nothing, home health agencies will receive a full market basket update in 2007. The draft recommendation that we have here reflects what we have done in this sector in the past when the update factors have looked very similar and we, on the screen, have the recommendation that Congress should eliminate the update to payments for home care services for calendar year 2007.

As we have noted, though we have made this recommendation in the past, they have received positive updates for the past two years.

The spending implication of implementing this would be a decrease then relative to current law, and we project no major implications for beneficiaries or providers because the factors suggest that agencies should be able to tolerate price increases without an increase to base payments.

Moving then just briefly from our discussion of the level of payments to the distribution of payments, we continue our thinking on whether or not we're moving the dollars around appropriately within the sector. This is just a summary of our thinking to date. We have research that suggests we have pretty significant product changes that occurred between the time they set up the payment system and the payment system that's operating today. The current home health product includes fewer visits than it did when they set up the payment system and a much higher proportion of therapy than it did when the system was created.

An overuse of therapy is consistent with the

incentives of the current payment structure. An agency receives about $2,500 additional for an episode that hits the therapy threshold versus an episode for functionally and clinically the same patient that receives nine or fewer therapy visits.

We've also measured in the past the average minutes of service within payment groups and we found that those average minutes per episode are too varied if they're related to costs to suggest that we've got homogenous cost within our payment groups.

And finally, as we discussed earlier this year in our cycle, we found a small but statistically significant relationship between case mix and margin, again with all the caveats that our model was not particularly strong in predicting costs generally.

Finally, this is kind of to close a loop for the commissioners and for the thinking, last year we proposed further research on some beneficiary characteristics that we had identified as being outside the current payment adjustment but they could be related to costs. And if they were related to costs, it might make it difficult for beneficiaries with those characteristics to access care.

So we were able to test this list of four beneficiary characteristics while we were running that model that we used earlier this year. So what we did is we looked at the case load of home health agencies. We used the OASIS patient assessment to measure these characteristics that are outside the payment system and then we compared home health agencies that had a very large caseload proportion of patients with these characteristics to see whether their profitability was related to that caseload.

Again we found that there was no statistically significant relationship between having a large proportion of patients with these characteristics and your profitability, absolutely with the same caveat, the model isn't very strong but I wanted to touch base that we are thinking about these characteristics and we have done a little bit of testing on them.

So with that, I'm certainly ready to take your questions on either the distribution questions or the level of payment questions.

DR. MILSTEIN: Thank you. That was terrific.

Do we have any basis for interpreting the significance of the annual 7 to 8 percent upward creep in

the number of episodes per beneficiary? There are obviously a number of interpretations of that upward creep, some more along the lines of sicker patients. Others implying perhaps an adaptation to the payment system by the home health providers.

Do we have any evidence that might shed light on which of those two interpretations, perhaps a third interpretation, might best explain this continued upward creep in the number of episodes per beneficiary?

MS. CHENG: I think our conclusion would be that it's probably both of those influences going on. When the payment system was set up CMS acknowledged that as soon as you create episodes, then there would be an incentive to deliver the same amount of care and stretch it into two payment episodes.

One of the things that we have observed, however, is that the average number of visits per episode has been really flat. So they aren't taking the same number of visits and just stretching them over two payment episodes. There does seem to be -- they're holding the average number of visits steady.

I know that CMS is looking at second and

subsequent episodes as a particular phenomenon. One of the things that they're trying to determine, too, is what kind of patient characteristics, who's using these second and subsequent? Are they a different group of people? So we'll have a little bit more data that. I'm not sure what I can bring you by January to tease those two influences apart.

MR. HACKBARTH: Just to follow on that, on page three is it the episodes or the episodes per user that are catching your eye? It looks like that's driven by the number of users. I assume users is the base unit. And since users may have more than one episode, that could increase the episodes. But it's the user growth that is the one that's gone up.

Am I interpreting the table correctly?

And then the historical context for that is that we had a big decline in the number of users with the advent of the cost limits and that persisted through the early days of the new PPS system and then it started going up again. That doesn't mean that it's good or bad but that's the historical pattern, like a U-shape.

MS. CHENG: Right. The number of users has been increasing but also the average episodes per user. They're

both going up. Not a lot.

MR. HACKBARTH: 1.7 to 1.7.

DR. REISCHAUER: Are these numbers consistent? Because if the number of users goes up by 6 percent, by definition the episodes have to rise because every user has to have an episode.

MS. CHENG: Right, but the number of episodes is rising faster.

DR. REISCHAUER: So then the user per episode should go up 1 percent. There's a rounding issue, I'm sure.

MS. CHENG: I can get you more precise numbers. The number of episodes per user going up is also consistent. One of the numbers I didn't put up here is length of stay. I measure the number of days between being admitted to home care and being discharged from home care. And that's been increasing as well.

So the average length of stay is actually starting to approach 60 days, which is suggesting that a lot of people are getting two episodes of payment during their stay of home health.

DR. REISCHAUER: 1.7 is 6 percent higher than 1.6, so it's probably 1.54.

DR. SCANLON: [Inaudible.]

MR. HACKBARTH: Now that we've resolved that.

MS. CHENG: What I'm taking away is don't over interpret the change here.

DR. MILSTEIN: I think what I'm asking is is there a way of shedding more light on the implications of this annual upward creep of -- Bob was saying -- 6 or 6.5 percent a year, with respect to the number of episodes per beneficiary?

DR. MILLER: Sharon, a couple of things on this. I suspect that there's not as much change here but can we calculate the difference in case mix over this time looking at the distribution of cases across the HHRGs?

But I suggest probably if there's changes in the mix of patients, it's probably inside those categories as opposed to across those categories.

MS. CHENG: We have seen the average case mix go up a little bit. Again it's this incremental...

DR. MILLER: Not in the 6 percent range though, for example?

MS. CHENG: What I'm pulling off the top of my head is we started off with an average case mix of about

1.2. And the last time I measured it in 2003 it had risen to 1.3.

So yes, you're seeing the case mix increase over this time, too.

DR. MILLER: So maybe that's one thing we can calculate.

A second thing is actually just a different version of the same question. Can we disaggregate the growth in the episodes per user by the different HHRG category? So you can see it's these HHRGs that are growing and not these. Or is it uniform and all of them are growing?

Just to get underneath it a little bit more to Arnie's point. I'm not sure how much light that sheds on it, but that's working from the data that's available as opposed to what's a perfect answer to the question.

MR. HACKBARTH: It would also be interesting to see more years. We've got two data points, two consecutive years. I don't know how much year-to-year variation there is in these numbers.

MS. CHENG: In 2001 it was 1.5.

MR. HACKBARTH: Okay.

Other questions or comments for Sharon?

DR. WOLTER: I just wanted to note that this is a rare instance in recent years were Montana is shown as a blue state.

[Laughter.]

DR. WOLTER: I did want to just pass on a few comments. I checked with some of our home health folks back home, and I think that the discussion about the situation in rural areas may be a little less rosy than has been portrayed. You can tell from the map that we have a number of counties, it would be at least 25 percent of our counties and a larger number of square miles, where there's not a home health service. I don't know how much that would be replicated in other rural parts of the country.

We've had no new agencies enter our markets since the year 2000 and have had a number closed. I don't know the exact number.

Also, there's concerns back home being raised about the fact that our margin data is only from the freestanding facilities. And in rural states my understanding is there's a larger percentage of hospital-based home health agencies than there are freestanding. At

that's certainly true in Montana where about two-thirds of the home health agencies are actually hospital-based. So we don't really have any information at this point about how they're doing margin-wise.

They are concerned that we don't have the access we might wish. The transportation costs across the larger areas they have to travel, of course, have gone up significantly recently. And so they have some concerns about feeling a little less rosy about some of those rural issues.

They had a few other things, Sharon, that I'll just send along to you that we can talk about offline.

MR. HACKBARTH: Others?

Okay. Thanks, Sharon.

Our final presentation takes us away from payment adequacy, you can hold your applause, to lab utilization.

MS. KELLEY: In October we discussed concerns that Medicare is not paying accurately for clinical lab services. As you'll recall, Medicare's payments are based on charge data from 1983 and the method for determining payments for new services is inefficient and likely to generate inaccurate rates. Improving Medicare's payment methodology

is important because the clinical lab benefit costs almost $6 billion in 2004 and has grown an average of 9 percent per year.

Today, Ariel and I will present some information on the lab industry and on the use of lab services by Medicare beneficiaries. We'll also update you on some issues related to quality concerns in Medicare certified labs.

As of August 2005 there were more than 192,000 labs in the U.S. The number of labs has grown on average about 2 percent per year over the last decade. Physician office labs, as you can see, account for about half of all labs but they finish a much smaller proportion of total lab services.

Most physician office labs perform only waived tests and/or certified microscopy tests. As you can see here, the proportion of physician office labs certified to perform only waived and/or microscopy test has increased steadily since 1995.

Waived tests are defined by the FDA as simple lab tests and procedures that can be performed at home or that are so simple and accurate as to make errors unlikely.

There are 42 codes that are classified as waived including dipstick urinalysis for glucose and white blood cells and spun hematocrit blood test for anemia. Certified microscopy procedures are 12 codes performed with a microscope by a physician, a dentist, or a mid-level practitioner that are considered moderately complex.

Medicare's payment rates for waived and microscopy tests generally are lower than for more complex tests but certification requirements are far less rigorous. Labs that are certified to perform waived and microscopy tests are not subject to routine inspections.

The independent lab sector is highly concentrated with the two largest independent lab companies, Qwest and LabCorps controlling an estimated 60 percent of the independent lab market and getting bigger. In November Qwest completed a $934 million acquisition of LabOne request which had been the fourth largest independent lab company.

Over the past few years, the overall climate in the lab industry was quite bright, largely due to the decline in managed care. From 1998 to 2003 the combined revenue in the independent lab industry grew by an estimated 7 percent per year. But industry analysts expect that the

industry will face increasing price pressures in the future.

The MMA imposed a five-year freeze on updates to Medicare's payments for clinical lab services. States are struggling with their own Medicaid budget issues and private payers are now attempting to contain premium increases, which may result in constraint payments for lab services.

Consolidation in the Independent sector is ongoing.

Now to quality. Prior to 1988 only labs that engaged in interstate commerce were regulated by the Federal Government, so many labs went unregulated. Under the Clinical Laboratory Improvement Act of 1988, or CLIA, CMS now certifies all providers of clinical lab services based on the complexity of the testing they conduct. For labs performing moderate or high complexity tests, other than the specified microscopy procedures I mentioned earlier, CLIA specifies quality standards for proficiency testing, patient test management and quality control and assurance. These facilities are subject to routine inspections and labs performing high complexity tests must meet stringent personnel requirements.

Lab performance improved substantially during the

first years following the implementation of CLIA. According to CMS, the proportion of labs showing no failures in proficiency testing climbed from 69.4 percent in 1995 to 87.4 percent the following year.

But in recent years new concerns have arisen about the quality of care provided in labs that furnished only the waived and microscopy tests. In 1999 state surveyors in Colorado and Ohio initiated onsite inspections of a random sample of labs certified to perform only those procedures. You'll recall that they normally have no routine inspections. The surveyors found significant quality problems in over half of the labs. In 2001 CMS went on to survey 436 labs in eight additional states and found similar quality issues.

As a result, beginning in April 2002, CMS began conducting annual visits to a small percentage of labs performing the simple tests. The effects of these visits on overall quality is not yet known.

More recently there have been reports in the press of quality problems in some hospital-based labs. This was the topic of a series of Congressional hearings last year. GAO was subsequently asked to review the requirements for

lab quality and to assess the effectiveness of the certification process and a report is expected early next year.

Ariel is now going to talk about our analysis of Medicare beneficiary use of clinical lab services and future work we have planned.

MR. WINTER: The next several slides are based on our analysis of Medicare claims data for services paid under the laboratory fee schedule. Some lab services are paid under the physician fee schedule. These are generally those that involve pathologist's time. These were excluded from our analysis.

Although there are over 1,000 tests in the lab fee schedule, the volume of test is fairly concentrated. This chart shows that the 10 highest volume tests accounted for 55 percent of Medicare volume in 2003 and half of spending.

According to OIG in 1997 over half of the test codes were billed fewer than 1,000 times. The most frequently billed service on the lab fee schedule is venipuncture, which is actually not a test. It accounts for almost one-fifth of total volume but only 6 percent of payments. This is because it has a very low payment rate of

$3 per blood draw.

Physician offices that don't have labs can bill for venipuncture. They can draw blood that is sent to an outside lab for testing. About half of venipuncture services are provided by physician offices that don't have labs.

If the test has an asterisk next to it on the slide, this indicates that the test has been growing faster than 10 percent per year between 2001 and 2003. And that's volume growth we're talking about here.

The second test on the slide, which is a type of complete blood count test, grew by 25 percent per year. It accounted for a higher share of payments in 2003 than any other test, about $450 million.

It's important to mention that many of the tests that are growing rapidly are recommended by clinical guidelines for the treatment of certain chronic conditions. For example, complete blood count tests and metabolic panel tests are quality indicators for congestive heart failure, and the lipid panel and hemoglobin tests are quality indicators for diabetes. It could very well be that much of the volume growth we've seen represents clinically

appropriate use of tests and this is something we plan to investigate further.

We also looked at the volume growth of various categories of tests compared to the growth rate for all test, which was 7 percent per year between 2001 and 2003, and that's the red bar at the far right on the slide.

The bar at the far left represents screening tests mandated by Congress prior to the Medicare Modernization Act, and these include pap smears and fecal occult blood tests. These tests increased by 10 percent per year between 2001 and 2003, and much of this growth is probably desirable.

The next bar shows waived microscopy tests which are often done in physician offices. These include prothrombin time lipid panel hemoglobin and urinalysis tests. These grew by 11.5 percent per year.

New tests that were added to the lab fee schedule in 2001 experienced very rapid growth of 28 percent per year. This category includes new types of bacterial blood culture tests, immunological tests and genetic tests. It's not surprising that new tests are growing quickly because they started from a small base. It could be that new tests

are substituting for older tests and this is something we'd like to explore further.

Medicare spending for all tests, which is not shown on the slide, grew by nearly 10 percent per year between 2001 and 2003, compared to 7 percent annual growth in volume, which is the red bar on the slide. Because payment rate stayed constant during this period, the fact that spending grew faster than volume suggests that there was a shift from lower paid tests to higher paid tests.

We then examined the distribution of volume by type of test. Despite their rapid growth, new tests accounted for less than 1 percent of total test volume in 2003. Screening tests were also 1 percent. Waived and microscopy tests represented over one-fifth of total volume.

We also looked at geographic variations in the number of tests per beneficiary. The national average was almost 15 tests per fee-for-service beneficiary in 2003 and there was a modest spread around this mean. The Mountain states had the lowest use rate of about 11 tests per beneficiary, and the New England states have the highest use rate of almost 17 tests per beneficiary. The ratio of the New England rate to the Mountain rate is 1.47.

We found much greater variation at the state level, as you might expect. The ratio of the highest use state to the lowest use state was 2.17 in 2003.

This slide shows geographic variations in the growth of tests per beneficiary. There was much more variation in growth rates than in the number of test provided, which is what we saw in the previous slide.

For the U.S. overall the volume of tests per beneficiary grew by 4.4 percent per year between 2001 and 2003. The West North Central states, in the middle of the slide -- which include Iowa, Kansas, Minnesota, Missouri and the Dakotas -- had the lowest growth rate of 2 percent per year. The East South Central states, also in the middle of the slide, had the highest growth rate of 6.6 percent per year, more than three times the rate of the lowest growth region. This region includes the states of Alabama, Kentucky, Mississippi and Tennessee.

There does not appear to be a correlation between regions with the highest growth and the regions with the most number of tests in 2003. We plan to look at whether geographic areas that provide more tests have better health outcomes and we'll be working with the researchers at

Dartmouth, including Elliott Fisher, on this question.

We plan to examine several issues in the future. We're going to look at changes in volume of spending by type of lab, hospital-based, independent and physician office. We'll be looking at oversight of lab quality. Whether there's a relationship between the number of test provided and the number of outcomes. And how Medicare rates compare to rates paid by other payers. We'll also be exploring policy options, including ways to improve the current payment system and alternative payment method such as competitive bidding.

We'd be happy to take any questions.

MR. BERTKO: Ariel, just a quick added suggestion for your explaining some of these. You may look at the risk adjustment for the health status of the people there. The East South Central is what I have jokingly referred to as the fried food belt and may, in fact, have some explanatory power there, although I doubt it's this much.

MR. DURENBERGER: Thanks very much.

Thanks for the comment at the end about trying to relate all of this to outcomes because I was really confused, as maybe others were, too.

But maybe in a real simple way, explain to me the consequence of low quality generally. You said something about they go in and investigate these labs and half of them are not meeting some standard.

Is this an overuse issue? Or is this billing that's for services not performed? What is actually going on when we talk about quality?

MS. KELLEY: The surveyors found in the labs that were performing the more simple tests a number of problems mostly related to the way the tests were performed. The requirements for the waived test are simply that they perform the test to the manufacturer's instructions. Many of the labs were found not to have manufacturer's instructions on site. Many of them were found to not be following them, even if they were onsite. Some of the labs were found to be providing services that they were not certified to perform.

So all of the quality issues were related to actual procedures and processes within the lab, as opposed to other issues related to --

MR. DURENBERGER: Is there a way, with regard to some of these, to take that into deciding whether or not a

properly administered test would have prevented an expenditure which Medicare is having to pay for? If you follow the question. In other words, what's the financial consequence of not following the rules and so forth?

MS. KELLEY: I'm not quite sure how to --

MR. WINTER: One thing we'll be looking at is whether there's a relationship between use of labs in different regions and outcomes in those regions, things like survival rates, readmission rates, those kinds of things.

We might also want to look at whether there's a relationship between areas that use lots of labs generally and areas that do very well in terms of quality indicators that involve lab use, like lipid testing for diabetics and glucose testing, that sort of thing.

In terms of quantify the financial impact in terms of downstream expenditures, it would be a tougher lift but we can see what we can do there.

DR. REISCHAUER: I wonder if in a way we're searching what's optimal lab use? Clearly we are, in some gross sense, underpaying labs. There seem to be a lot of tests going on and they're growing at a very rapid rate so that doesn't seem to be a problem. But the question is how

much variation should there be across the country?

One way is to look at Dave's area and see what the distribution is there. I was wondering if Jay or some capitated health plan could give you the data for their Medicare caseload, numbers of tests and types of tests, the distribution that you could -- where you have the incentives aligned for optimal use of inputs like tests. And you could compare it then to what's going on in the fee-for-service system.

MR. HACKBARTH: Jay, can you bring that to the next meeting?

DR. CROSSON: Yes, I can have it tomorrow.

In all seriousness the answer is yes, we can do that.

DR. NELSON: To respond to Bob, in many instances the physician ordering the test doesn't get any kind of benefit at all. It's a commercial laboratory that does it or at the most they get a drawing fee.

DR. REISCHAUER: I'm not pretending there's necessarily a financial motive behind this. What we're talking about is really quality of care and efficient provision of care. That's all.

DR. NELSON: And to some degree, you may find increased utilization in Jay's shop because they're paying more attention to following the guidelines.

DR. REISCHAUER: I'm agnostic on what we find.

MR. HACKBARTH: Even if the physician, as you correctly point out, is often not benefitting directly from the increased utilization there still might be a different attitude towards testing for a physician that works within a constrained system and they know that they're working within a defined budget.

So in neither case are they getting direct financial benefit but one knows that hey, we've got to live within a budget and the other is working in an open-ended fee-for-service system.

DR. REISCHAUER: And one is bearing the liability costs themselves and the other a corporation is doing it for them. So there's a lot of reasons.

DR. CROSSON: I just had a simple question about the second slide. 38 percent of the labs are not physician labs, hospital labs or independent labs. So what are they?

And then to what extent -- what is the volume there? Is that 38 percent of the labs but a small fraction

of the volume?

MS. KELLEY: Yes, that's exactly right. The labs in the other category run the gamut from home health agencies, SNFs, nursing homes, dialysis facilities. Obviously, these facilities perform a lot of lab services but many of the services that they provide are covered under other payment systems.

In terms of the Part B clinical lab fee schedule, a very small proportion of those labs are paid under the fee schedule.

One of the things we're having a little difficulty sorting out right now is the volume of services provided by physician office labs versus independent labs for Medicare, but we do know from some other data that's dated if you will that physician office labs provide a pretty small proportion of the total.

I don't know if that answers your question.

DR. CROSSON: Can I just make one other point? Going back to that list of tests, to get to the issue of value or efficiency, one of the things I don't see on there, for example, as a clinician are useful but much simpler and less expensive tests that substitute, in many cases, for

some of these. For example, hematocrit instead of a complete CBC or a serum sodium and potassium as opposed to a complex metabolic panel.

There are some issues, and I don't know all the issues that go into choosing those. But I was sort of surprised when I looked at it to see the absence of some simpler test which are less costly.

MR. WINTER: It could be there are incentives in the payment system to bill for the more bundled panel of tests than the simple individual tests. And that might explain why you're seeing the more comprehensive bundle of tests.

DR. NELSON: For the sake of completeness, it would be helpful to include some comments about proficiency testing, particularly for physician office laboratories, including instances in which it's not required for certification but in which the physician nonetheless wants proficiency testing to assure accuracy.

CMS has some data on that and ACP has some data on it.

MS. DePARLE: I spoke with Ariel about this after our first discussion of this a couple of months ago but I

had understood from people at JCAHO and from some others that there are some real issues with a shortage of lab technologists, technicians and in particular, in some states where there may be higher standards, more requirements for staffing and oversight and in some facilities where there are more complex tests being done that require, I'm told, a higher level of certification, that that is affecting labs and causing them problems and quality issues, et cetera.

I know you haven't yet drafted a chapter but I'd be interested in knowing if you know anything about that yet and if we'll be able to assess that?

MS. KELLEY: We've read reports of that, also. At this point we don't have any data necessarily backing that up, but we've heard similar reports. We're looking forward to GAO's report because they were looking particularly into the accreditation issue.

Right now labs have the choice when they apply to CMS for certification. If they're performing the moderate and higher complexity tests they choose whether they want to be surveyed by state surveyors or by a private agency like JCAHO.

One of the things that GAO is looking into is how

that process works and whether or not the accreditation across the board is covering all the bases. So I think that will get to some of your issues.

MR. WINTER: We're in the process of setting up a meeting with JCAHO to find out how their accreditation process works for labs, what kinds of problems they've been encountering and how they're dealing with that.

DR. NELSON: Talk to COLA, too. COLA certifies more office labs than the Joint Commission.

MR. HACKBARTH: Thank you very much.

We are now finished with the presentations for today, well ahead of schedule. So the first order of business will be to have our public comment period, but I'd like to ask the commissioners if they can stay for a few minutes after we're finished. I'm looking at the scheduled for tomorrow and thinking about the snow and I think it might be helpful if we could have a brief conversation after the meeting and that may allow us to get out of here quicker tomorrow. So please stay after the meeting.

And now we'll go to the public comments, with all of the usual ground rules about brevity and no repetition and all of that stuff.

MR. MERTZ: I can't repeat anybody because I'm first.

I'm Alan Mertz. I'm President of the American Clinical Laboratory Association.

I want to thank you for focusing on labs and appreciate the presentation that was given. We appreciate the rigor in which they're looking at labs. We welcome that.

Clearly, we've had problems with policymakers not completely recognizing the value of laboratory services. Just a couple of facts to keep in mind. For the last 20 years labs have been reduced by 40 percent in real terms under Medicare. The fee schedule has not been updated fully for inflation but twice in the last 15 years. It's frozen until 2008. We've compared us to all the other parts of Part B Medicare and we have lagged behind all of those other factors.

I did want to comment on Mr. Durenberger's comment about maybe the labs are maybe billing for services not performed. It's actually the other way around. When we're sent a test, we perform it that very night. Somewhere between 5 and 10 percent of the time we're not paid. And

for some tests, we're paid very, very low compared to third parties. Particularly in new technologies we're underpaid.

Laboratory spending is only 1.6 percent of Medicare spending. It's a tiny part of the budget but it has a huge impact on patients' lives and other Medicare spending. But while we're only 1.6 percent of Medicare spending, we make up 60 percent, 60 percent, of the individuals' medical record. And laboratory spending influences 60 to 70 percent of all clinical decision making.

We think we need to look at laboratory spending in this light, in a new light. It's not so much what is the cost of a lab test but rather what is the benefit of labs to the program and to the patient's health? When we think about our own experiences and those of our loved ones, I think this comes to life. I'll just give you an example and then I'll conclude.

I have a close friend. She just entered Medicare at 65. She had her first glucose and cholesterol tests in many years. These tests cost $11.54. Based on that her doctor diagnosed that she has adult onset diabetes, high cholesterol. And as a result, she's changed her diet, she's increased her exercise. She's gone on statins. She's now

significantly lowered her risk of going on in diabetes, its associated complications, heart attack and stroke.

When you consider the $11.54 cost of these tests compared to the tens of thousands of dollars that will be saved in her care, I think this is really how we should try to look at this.

There are many more examples of this that I won't go into.

Again, we welcome the dialogue we're having with MedPAC. I could have answered all the questions that you posed a few minutes ago. So we welcome the dialogue with Ariel and the staff because I think we can help them.

But we're confident that if you look at labs in this new way and looking at the value of labs and not in a silo, that MedPAC will embrace the notion that lab services add value, they save lives and they save money.

Thank you.

MR. HUNTER: Mr. Chairman, members of the Commission, Executive Director Miller, MedPAC staff, my name is Justin Hunter. I am Vice President of Government and Regulatory Affairs for HealthSouth.

I know that there was some discussion earlier

today about some of our cost reporting data. The short of it is this. We've been working on it, we're working on it and we will continue to work on it. We have disclosed as much as has been asked of us by staff, MedPAC staff, and we continue to work through our cost report data.

That has been the result of a number of activities that occurred several years ago under prior management and leadership of the company.

I want to touch upon a couple of points that were discussed today during the IRF presentation. First and foremost, I want to underscore our very strong agreement with the notion that the right kinds of patients ought to be treated in inpatient rehabilitation hospitals. We embrace that.

Currently and historically there are at least three mechanisms that I can think of that are designed to ensure as best they can be ensured that the right kinds of patients are treated in rehab hospitals, the first of which is something known as the HCFA Ruling 85-2. It's a set of eight criteria that were issued by CMS back in 1985 and they have been the gold standard for determining the medical necessity and appropriateness of inpatient rehabilitation

and whether a patient instead could be treated elsewhere, such as in a SNF or home health.

Secondly, there are the local coverage determinations developed by various fiscal intermediaries. 75 percent of our claims happen to go through one fiscal intermediary and that fiscal intermediary has developed an LCD for inpatient rehabilitation. We live by it as best we can.

Thirdly, there are fiscal intermediary claims review activities. And when I'm not at MedPAC and elsewhere, I find myself on the phone oftentimes dealing with claim denials that are issued by our FI.

In the long run, however, and in the longer term, there was mention of patient assessment instrument. That's been discussed here before. We welcome that. We welcome the development of a patient assessment instrument. We welcome the development of integration in the post-acute setting. We think that long-term post-acute care ought to focus less on the sign above the door and more on the needs of the patients, their outcomes and their performance of providers.

So the 75 percent rule. I think there was a lot

of discussion about that today, in terms of the uncertainty that it has created. And indeed it has created a great deal of uncertainty in this space.

There were several percentages that were offered in terms of caseload decline and volume decline. I think it's important for each of you to take into account that this volume decline represents a material underestimation on the part of CMS when it implemented this policy. In fact, they recently acknowledged it in a memorandum that they issued last week on the 75 percent rule.

My point here is there is, in fact, a lot of uncertainty about the 75 percent rule now and going forward. In that regard we are greatly appreciative to MedPAC for taking into account the effects of the 75 percent rule as it relates to your work on payment adequacy.

Lastly and very quickly, Chairman Hackbarth, you mentioned LTCH criteria. We don't occupy a great deal of space in the LTCH world but we do occupy some. We strongly believe that we need to move away from the current standard basically of the 25-day average length of stay and begin to look at real criteria aimed at determining who is best appropriate for an LTCH level of care.

HealthSouth stands ready to work with MedPAC, with Congress, and with CMS to achieve these kinds of objectives. We certainly appreciate the opportunity to have the dialogue here today, the dialogue that we've had on an ongoing basis with the staff.

I thank each of you for your time.

MS. ZOLLAR: My name is Carolyn Zollar. I'm Vice President of Government Affairs and Policy Development for the American Medical Rehab Providers Association and I'll give you a few dittos to what Justin just said, but I have a few other comments.

I appreciate the care that's been taken in the analysis the staff presented to you today. I would note for the comment that was raised earlier that one reason that the average difference between payments and costs pre-PPS is there's a TEFRA limit that limited total payments to the facilities. I don't know if that was mentioned. In addition to Sally's point that the complexity of care and the cost of that complexity of care and payment based on costs was also not recognized under TEFRA and was one of the driving forces in the structure of the PPS.

We also believe the decline in volume has serious

cost implications and impacts on margins, which you saw today in the analysis, and which we raised in the letter to you. We will continue to work with the staff on additional analyses and in the future on the issues that were raised about potentially looking at the structure of the PPS, which is a whole separate issue, and on the larger issue of integration of post-acute care, be it data assessment tools or payment systems, which will be the next letter.

Again, we appreciate your continued concern as our industry is going through a very, very volatile time as the data showed today.

Thank you for your attention to this issue.

MR. CHIANCHIANO: Good afternoon. I'm Dolph Chianchiano, Vice President for Health Policy at the National Kidney Foundation.

We appreciate the Commission's concern about malnutrition among dialysis patients. Malnutrition puts dialysis patients at increased risk for hospitalization, which in turn has implications for the Medicare program, but also increased risk for mortality.

I'd like to make some footnote-type comments with regard to that issue. First of all, this phenomenon may be

the flip side of the productivity phenomenon that we have noted in the dialysis industry. The typical nutritionist in a dialysis facility has a caseload of at least 150 patients. Some have caseloads up to 200 patients. With those caseloads and with the complex metabolic problems that these patients encounter, it is difficult to provide the kind of services that would help resolve the malnutrition issues.

Furthermore, Medicare does not provide payment for nutritional supplements. In addition, Medicare does not allow dialysis providers to give or supply nutritional supplements free of charge to indigent patients. And that, I submit, is an issue that the Commission might want to consider.

Finally, the National Kidney Foundation, in its clinical practice guideline development program, has a specific guideline on nutrition for kidney patients. I'd be glad to share that information with you.

Thank you.

MR. CALMAN: Good afternoon. My name is Ed Calman. I'm General Counsel the National Association of Long-Term Care hospitals.

I'd like to make two brief points concerning the

recommendation for update factor and then tell you about two matters that our association is undertaking which you should find of interest.

First of all, this year CMS regulations provide for a one-time adjustment to the standard amount to account for approved coding. A regulation was adopted when the PPS was adopted. It's 42 CFR 412.523(d)(3).

This is a customary and usual adjustment that's made to new PPS systems. When this adjustment was made to the IPPS system, the standard amount went down. When it was made to the IRF system a year ago, the standard amount went down. And I suspect that the standard amount will go down with long-term care hospitals. This rule is currently under development and will be proposed, we are told, either in January or February.

So I think in arriving at your final recommendation you should consider the effect of this one-time adjustment of the standard amount on the long-term care hospital industry.

Secondly, I want underscore I think this is a very important matter. The profit margins that were shown were measures of central tendency. There are long-term care

hospitals that have poor to mediocre margins. And those are the hospitals that serve the medically indigent.

You can pick most of them out from the data because you can look at the Medicaid days off the cost report.

I think it's appropriate to assess the effect of a zero update factor on those hospitals. It's more difficult to affect the assess of a zero update factor on charity care. That's a very important matter for long-term care hospitals because the indigents that access long-term care hospitals are crossover cases. They enter with Medicare Part A, they're very ill, they exhaust Part A and they cross over. And many states in this country have very meager Medicare day coverage. In Texas it's 30 days, in Mississippi it's 30 days and in Alabama's it's three.

There's a number of long-term care hospitals in those states that serve those patients and they need margins to serve those patients from the Medicare program because there's no DSH adjustment to long-term care hospital PPS.

I think that, in addition to assessing the question of serving the medically indigent, that there should also be an assessment of the effect of a zero update

factor on urban and rural differences and the effect it will have on access to care in those locales.

Moving on, I would like to tell you some of the activities that we're involved in which I think go to addressing more long-term issues. I was going to say long-term care issues, but it's long-term structural policy issues.

We have developed outcome criteria. We have finished the first multiple site, 23 site ventilator weaning study in long-term care hospitals showing outcome data, costs, functional status on admission, discharge and 12 month after discharge.

We are also moving forward with a database so we can assess outcome measures on patients and we have developed clinical criteria to determine the appropriateness of admission continued stay and discharge to long-term care hospitals, and we're currently engaged in a professional validation of those criteria.

So we are certainly trying to be part of the solution in this area. We welcome integration of payment systems. But we certainly hope that along the way that the providers that are serving especially the medically indigent

are not disadvantaged.

So I thank you very much for your consideration of those factors.

MR. WATERS: Good afternoon. My name is Bob Waters and I would like to make a few brief remarks on behalf of the American Association of Bioanalysts, AAB. Our organization represents the owners, the directors, the supervisors and technologists of community clinical laboratories.

Advances in clinical laboratory testing are responsible for detecting and diagnosing diseases faster and more accurately than ever before, allowing doctors to prescribe more effective and often less invasive treatment options. In fact, laboratory tests play a leading role in more than 70 percent of all medical decisions.

Despite the importance of laboratory testing, patient access to laboratory tests is threatened by inadequate reimbursement. Over the past two decades reimbursement for laboratory testing has been cut by 45 percent. Since 1990 the full CPI update for clinical laboratory fee schedule has only been applied four times.

Moreover, the laboratory industry has absorbed 15

percent of the provider cuts in the Medicare Modernization Act of 2003, which included a continued CPI freeze through 2008.

In addition, the specimen collection fee paid to laboratories establishment in 20 years ago at $3 has never ever been increased, even for inflation. The current cost of specimen collection ranges from $6 to $9 due to normal price inflation as well as updated blood borne pathogen regulations and new Sharps systems requirements. It has become incredibly more expensive to collect those specimens and that cost is borne by the community clinical laboratories.

During this time period of frozen payments for clinical laboratories services and specimen collection, the independent laboratory sector has become ever more concentrated. I know that was noted in some of the materials that were presented to you earlier today. If reimbursement levels remain flat, coupled with the introduction of new pricing models for laboratory services that have not been adequately tested, independent community laboratories could easily disappear from the market.

Policymakers must ensure that new policies such as

competitive bidding live up to their names and truly create more competition rather than less competition, that they don't further ensure that only a few laboratories dominate the entire market. I think any economist who would look closely at the independent laboratory sector would recognize that this is a significant issue in this field. Only with the diversity of laboratory services can our health system hope to serve all segments of the Medicare patient population, including those living in rural areas and those that are in nursing homes.

Diversity of laboratory services is also crucial during natural disasters and bioterrorism events. These events have the capacity to disrupt our air transportation system, leaving our local laboratories sometimes as our only and last line of defense.

As MedPAC examines the laboratory industry, AAB urges the commissioners and their staff to undertake a comprehensive and accurate review of the entire independent laboratory market, as well as the entire laboratory market, and look at the essential and vital services that are provided to the local communities.

Thank you very much.

MR. HACKBARTH: Okay, thank you.

So if the people in the audience would bid us adieu and we'll see you tomorrow and the commissioners will stay, we'd appreciate that.

[Whereupon, at 4:59 p.m., the meeting was adjourned, to reconvene at 9:30 a.m. on Friday, December 9, 2005.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 9, 2005
9:33 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

P R O C E E D I N G S

MR. HACKBARTH: Okay, good morning.

We have two presentations scheduled for today, one on valuing physician services and the other on assessment of payment adequacy. There will be draft recommendations to discuss on the both of these. The final votes, of course, do not occur until January.

Kevin, are you going to lead the way on the first item?

DR. HAYES: Yes.

Our topic here is valuing services in the physician fee schedule. This is a topic that you considered in September and again in November. We're here today to briefly recap points made previously and to present some draft recommendations.

Before we begin, I would like to just take a few moments to address points made by Dr. William Rich during the public comment period at the November meeting. Dr. Rich is the Chairman of the Relative Value Scale Update Committee or RUC. Because some of our draft recommendations involve the work of the RUC, Glenn asked staff to review the points made by Dr. Rich and to offer some possible responses.

The first point that Dr. Rich made concerned valuation of evaluation and management services. The point here was that an argument can be made that not enough revenue has shifted toward E&M services over the course of experience with the physician fee schedule, but that valuation of E&M services is not the reason for this. Instead, it's growth in the volume of other services, particularly imaging and tests.

A way to respond to a point like this would be to say there is much agreement between this point and work of the Commission. Recall, in particular, at the April meeting researchers from the Urban Institute presented work on changes in the volume of physician services and changes in the valuation of those services and showed that over the course of the fee schedule E&M services appear to be losing ground in terms of total volume of services received by Medicare beneficiaries. At the same time, the valuation of those services has gone up.

So there's some agreement with the point made by Dr. Rich.

The other way to respond on this matter would be to note that in the draft recommendations that we're going

to present in just a few minutes that for the most part they concern not the valuation of E&M services but focus more so on services in the fee schedule that may be overvalued. The concern here is that overvalued services could be too profitable, could be creating some financial incentives for unnecessary use of those services.

Another point made by Dr. Rich concerned the fact that the RUC is an expert panel and not necessarily a consensus or representative panel. As you'll see, the draft recommendations recognize that CMS has the option to use the RUC as a source of advice and has chosen to do so.

The question before the Commission is whether it's possible to make some recommendations to try and improve upon the process for review of RVUs.

On the specific point of whether the RUC is a representative panel, as you know the Commission has received letters on this point. Staff has met with physicians who have viewpoints on the matter. As near as we can tell there's kind of two opposing viewpoints on this. On the one hand, we have the perspective that the RUC is an expert panel, that physicians that serve on the RUC put aside the interests of their specialties whenever they do

their work. The figure of speech that's used here is that RUC members put on their RUC hat when they perform their duties.

On the other side we have the perspective of those who feel that the physicians who perform evaluation and management services are not adequately represented on the RUC, that these are very important services, and that the problem here is that E&M services account for a very large share of spending in the fee schedule, and that any change in the valuation of those services can have very profound impacts on payments for other services.

The perspective there is we need adequate representation of those interests on the RUC in order to ensure adequate valuation of those surfaces.

The final point here concerns the mechanism for identifying overvalued services. Here again we see quite a bit of a agreement between what the Commission has been considering and Dr. Rich's point, which is that there does need to be a mechanism outside of the RUC, probably at CMS, for identifying overvalued services.

The other point that Dr. Rich made, and I think there would be some agreement on this as well, is that CMS

staff are overworked and that perhaps there is a need for the Congress to consider some change in responsibilities and some steps toward ensuring adequate resources for CMS.

So that's our attempt here to try and address those points that were made at the November meeting.

We now want to move on to the core of our presentation here today. Dana is going to first recap some points that we've made previously on these matters.

MS. KELLEY: As you know, we've been presenting information about this issue to you over the past few months and we discussed that making sure services are adequately valued is important in order for Medicare to be a prudent purchaser.

Misvaluation means that Medicare is paying too much for some services and to little for others. As a result the market for physician services can become distorted with physician decisions influenced by financial considerations rather than solely by clinical necessity. That can increase or decrease volume inappropriately.

Over time, as some Commissioners have pointed out, misvaluation can make certain specialties more financially attractive than others, which has implications for the

supply of positions.

As you know, the Medicare physician fee schedule was implemented largely to address what was widely perceived as misvaluation in the old charge-based method of payment. As expected, under the resource-based payment method, payment rates for evaluation and management services increased relative to other services such as surgery and procedural services.

But there are signs that misvaluation of physician services continues to be a problem. Aggregate payment for certain types of services has grown at widely disparate rates with growth in payments for imaging and minor procedures outpacing that of visits and major procedures. Consequently, as you can see here, payments for E&M services declined as a share of total payments between 2002 and 2004, as did payments for major procedures. This is largely due to differences in volume growth across services.

But the Commission has voiced concerns that differences in the profitability of services is partly responsible for the differential volume growth.

The results of CMS's reviews of the physician work relative values and the fee schedule provide another

indication that misvaluation is an issue. CMS is required by law to review and, if necessary, refine the fee schedules relative values at least every five years. CMS completes its five-year review with substantial help from the RVS Update Committee, or RUC, which as you know is a panel convened by the AMA and physician specialty societies.

As you can see here, during the first two five-year reviews, completed in 1996 and 2001, the RUC recommended many more increases than decreases in the relative values of services. The reviews yielded those results even though the factors that can lead to a service becoming misvalued suggest that services may be more likely to become overvalued over time than undervalued. The vast majority of these recommendations were accepted by CMS. In both the first and second five-year reviews, the growth in the RVUs for so many codes would have increased total payments so CMS was required to reduce payments for all services to maintain budget neutrality.

Over the past few months we've discussed several reasons why misvaluation of services persist, focusing on the role of CMS and the RUC in the five-year review process. It appears that throughout this process CMS relies too

heavily on physician specialty societies to identify services that merit review and to provide evidence in support of increasing or decreasing the relative values of services under review. The result is that the process does not do a good job of identifying and correcting overvalued services.

Today Kevin, Carol and I have five draft recommendations for you to consider which should help improve the five-year review process.

DR. HAYES: Before we get to that first recommendation, let me just provide a couple of slides here to set the issue up. It concerns the specialties represented on the RUC.

What we're after here is to consider really the composition of the RUC and which types of physicians are represented there. Our goal here is to try and respond to a point made at the November meeting that perhaps it is time to move away from a Senate model for the RUC.

Today, we see that there are 23 different specialties represented on the panel. Those seats are fairly evenly divided between medical and surgical specialties. A concern would be that this composition is

not necessarily representative of the types of services that physicians furnish to Medicare beneficiaries.

There are different ways to look at this issue of representation. One is shown here on this slide, which compares spending by type of service with the specialties on the RUC. What we see here is that evaluation and management services account for about 42 percent of spending under the physician fee schedule. But then when we look at the composition of the RUC, we see that only about 30 percent of the specialties represented there derive a majority of their Medicare revenues from E&M services.

There are other ways to look at this issue. For example, if one wanted to take the perspective that we view primary care physicians, let's say, as an important group of physicians furnishing services to Medicare beneficiaries in terms of serving as a first point of contact in the health care system -- continuing care, chronic care, chronic care, all of that -- that we would see here that we have three specialties representing primary care: family practice, internal medicine, pediatrics. Yet those same specialties account for -- and those therefore are about 13 percent of RUC membership. Those specialties account for 20 percent of

spending the fee schedule and they account for about 23 percent of the beneficiaries seen by physicians billing the program.

There are a number of different dimensions to this issue of representation. What we could say is that given those different dimensions, it's wise for the medical community to step up here and offer some perspective. It's clearly the kind of a situation where we have a moving target and it's not clear exactly what to do, but some input from the medical community would be very helpful.

We are now ready to look at the draft recommendation that we drafted here which reads as follows: In establishing and reviewing relative value units the Secretary should receive advice from physicians who are representative of the specialties that most often produce services to Medicare beneficiaries.

We have considered the implications of this, both from the standpoint of spending and beneficiaries and providers. On the spending side, the relative value units and the fee schedule, any changes in them are, by law, implemented in a budget neutral manner. So we do not anticipate spending applications associated with this

recommendation.

There may be some redistribution of payments, but we do not anticipate large impacts for Medicare beneficiaries. There may be some redistributive effects from a provider payment standpoint however.

I should point out, by the way, that this profile of implications for spending, beneficiaries, providers, that applies for all recommendations that we'll go over today.

That's this recommendation and we're ready to move on to the next one. Carol will present that.

DR. CARTER: Given the tendency of the current process to identify undervalued services and to recommend increases in RVUs, it is important that CMS play a lead role in identifying misvalued services and revising relative values when appropriate. Yet we recognize that CMS has limited resources.

Our second recommendation considers one way for CMS to effectively address biases of the current valuation process. It reads: the Secretary should establish a group of experts to advise CMS throughout its process of reviewing work RVUs. This group should include carrier medical directors and experts in economics, technology diffusion,

and physician payment from the private sector.

Currently CMS uses ad hoc refinement panels to help it assess large differences between valuations it has proposed and public comments it receives. The panels include carrier medical directors and physicians.

Building on this idea, we propose that CMS establish a group of experts that would assist it in other areas of the review process. The group could include representatives from medical specialties, carrier medical directors and experts in the fields that I mentioned. Experts in medical economics will help CMS decide how to adjust RVUs to account for any economies of scale that accompany volume growth. Experts in technology diffusion would help CMS evaluate the efficiencies of learning by doing associated with new services.

Private payers would provide information about distortions in payment rates gathered from the markets that they operate in.

To ensure that the panel has the medical expertise required to consider the wide array of services the membership could have a core set of experts and a varying set of clinical experts tailored to the specific services

under review.

We envision the group being involved at two key points in the RVU process. First, it could review the codes that CMS's data analysis have identified as potentially misvalued and make recommendations to CMS about which services should be forwarded to the RUC for further consideration. Second, once the RUC's recommendations are submitted back to CMS for consideration the group could assist CMS in reviewing the evidence, arguments and service valuations. Its assistance would help counter any biases in the RUC recommendations and may reduce the public comments it receives on the valuations of services.

The next recommendation would help CMS improve the identification of misvalued services. Currently the vast majority of services that are reviewed during the five-year review process are identified by physician specialty societies and are likely to be perceived as undervalued rather than overvalued.

It's important, therefore, for CMS to identify codes that may be overvalued and submit them to the RUC for review along with supporting evidence. Analyses of Medicare data such as changes in length of stay, site of service,

volume, and practice expense could provide crucial information to support agency claims that services are overvalued.

The draft recommendation is that the Secretary should institute automatic reviews of services that have experienced substantial changes in length of stay, site of service, volume, practice expense, and other factors that may indicate changes in physician work.

The recommended expert panel that Carol spoke of could assist CMS by reviewing the codes identified through data analyses and consider which services warrant further consideration by the RUC. The panel could also help CMS in developing additional evidence providing support for correcting misvalued services.

The fourth proposed recommendation would help ensure accurate payment for recently introduced services by instituting automatic reductions in work relative values after a specified period of time. This would reflect the fact that we expect the work involved in furnishing many new services will decline over time as physicians gain familiarity with it and become more efficient.

The draft recommendation reads that the Secretary

should automatically reduce the work relative values for recently introduced services after a specified period of time.

New services would be scheduled for reductions after a period of time such as three years or could be reduced gradually over a somewhat longer period. The Commission would specify that CMS should conduct research to determine if there's a typical trajectory to the decline in work that occurs in the early years after a service is first introduced.

MedPAC would also indicate that specialty societies and other interested parties should be given an opportunity to submit evidence supporting a specific RVU for a service scheduled for automatic reduction. In the absence of compelling evidence, however, reductions would be implemented.

CMS should also consider if services related to the new service in question should also be reviewed and revised.

DR. CARTER: Although the majority of services furnished to beneficiaries has been reviewed and we're proposing ways that CMS could improve the way it identifies

services that warrant examination, our last recommendations considers those services that otherwise would not get reviewed.

It reads to ensure the validity of the physician fee schedule the Secretary should establish a process by which all services are reviewed periodically.

Since the work RVUs were established more than 15 years ago about one-sixth of the work RVU volume has not been reviewed and the relative values may no longer reflect current medical practice. This recommendation would require that CMS consider every service periodically so that the fee schedule is kept as accurate as possible.

Because this volume is spread over so many codes, about 50 percent of the individual services under the fee schedule, we recognize that it is not feasible for CMS to take a review of this scale. One way to accomplish this would be for CMS, on an annual basis, to select a subset of codes from those that have not yet been reviewed and have a group of experts examine the current valuations. Services that appear to warrant further review could be forwarded to the RUC. The RUC, in turn, would use its regular process to review the services and make recommendations to CMS.

The Secretary should choose a strategy that best fits the agency's resource constraints.

We acknowledge that some services that have not been reviewed have very low volume and that using the valuable RUC and CMS resources to validate their work RVUs is not sensible. To consider the RVUs for very low volume services, CMS may want to indicate to the expert group whether more recent reviews of services with similar components or services that are somewhat similar, what those reviews have done to the RVUs.

We also recognize that this recommendation places additional burdens on the RUC and on CMS and that both may require additional resources to implement this recommendation. But we note that some process is required to ensure that services that otherwise would not get flagged are periodically considered so that the work relative values are kept as accurate as possible.

This ends our presentation and we can answer any questions that you have.

MR. HACKBARTH: This has been a very helpful process for me over the last several sessions. I've learned a lot about the RUC that I didn't know before and that's

good. I think we've had a good exchange with people who have been involved, and both through Bill Rich's oral statements here and letters that we've gotten from him and many of the specialty societies.

As a result of that, I guess I am more comfortable today than I was at the beginning of the process that what happens within the RUC is analytical as opposed to political. Being the cynic that I am, I'm not out 100 percent confident that there's no politics involved, specialty politics involved, but I feel better about the process than I did when I knew less about it.

It still seems to me that we have, even if you stipulate that it's principally an analytic process within the RUC, we still have very large problems about what issues come before the RUC. I feel even more strongly about that concern than I did at the beginning of the process.

I think one of the problems that we have is that under the current structure I guess it's left to CMS to drive what comes before the RUC and make sure that they're looking at potentially overvalued codes. But CMS is chronically short of resources. This is one of the things that apparently seems to fall off the plate on a regular

basis with severe consequences, really significant problems.

We have a series of recommendations. I think two through five, in various ways, try to address that what gets on the plate issue. And I feel very good about that. I think that's quite urgent to do.

Recommendation one addresses the internal dynamics of the RUC, tries to address them through altering the representation which, all things considered, I think might be a good thing to do, although I'm less confident that that's dramatically going to alter the output of the RUC, changing a few seats, shifting the balance between specialties. It's less clear to me that that's going to have a dramatic affect on the ultimate outcome.

So that's sort of my take on this journey that we've been on in the last few months. From there let me open it up to other questions or comments.

MR. MULLER: Glenn, I share your comments and commend the staff for doing this work and edifying all of us.

Let me just talk to the relationship between recommendation three and four and whether you consider -- maybe go to four first -- making four one of the triggers

under three. So for example, rather than saying automatically reduced, you could have the newly introduced services be one of the criteria under three for services that get reviewed. I'm sure you considered that.

Could you talk just a little bit about why you went this way, rather than making it one of the triggers under three?

DR. HAYES: The thought was that under recommendation four there is pretty compelling evidence that work RVUs would go down with newly introduced services. We cited in the draft chapter some work done by a HCFA contractor and they ticked off a list of reasons why they would think that work RVUs would change, having to do with learning by doing and so on.

So we thought that that was compelling enough evidence to support the idea that we would expect RVUs to go down for newly introduced services after a period of time. That was pretty much it.

MR. MULLER: Is there any kind of distribution on that where some -- I would assume that some services, in fact, seem to be undervalued when they first started. It may not be a bell curve so it may be fairly skewed. But I

assume that some services, in that sense, are undervalued.

So I wouldn't assume it's 100 percent of services that basically, as you say, become less work over time. If you follow me.

So my suggestion is you consider -- if that is the case, again it may not have to be a bell curve in terms of ones that become easier over time versus harder over time. But you may want to consider this as one of the triggers under three.

DR. MILLER: [off microphone] By triggered, you mean something that was --

MR. MULLER: Could you do three, please?

In terms of -- just make that instead of site of service. volume, practice expense, you say that it become one of the criteria that indicate perhaps significant change. So you would say that new services, after period of X, be one of the ones that you automatically consider under these automatic reviews.

DR. REISCHAUER: That makes a lot of sense but I'd want to look at the information and see whether it was like the engineering curves in manufacturing where what you see is after two years a reduction of 10 percent, after three

years 15 percent. And so you might not want a single review. It might be easier really to put in a function for this stuff. But it depends.

MR. MULLER: That's why I ask what the distribution of that curve is. If it's that kind of step function in a predictable way for 90 percent of procedures, then you can feel fairly comfortable. If it's more bell curve, you obviously think about it in a different way.

DR. SCANLON: I think there are two broad things about the context that we should at least make note of here. One was an issue that came up yesterday.

It you're going to have the right fees we have to invest in the information and the process to generate them. And I think that, in part, relates number five, which is going to be the most expensive of these recommendations to implement.

We should underscore that given the amount of money we spend with these fees, making that investment is a prudent and wise thing to do. I would like to underscore that.

The second thing is, while we're talking about the RUC today and the work component, the issue of misaligned

physician fees applies to all three components of the fee. And we should remind people that there needs to be work on all of them to keep them all in line if we expect the incentives to be appropriate in terms of services.

Again I guess I think that fifth one really is the most important. And I guess I'm not sure that I like it as five, as opposed to our primary recommendation should be that the Secretary make sure that all procedures are evaluated periodically so that they all are in line, makes the investments necessary which may involve doing new types of data collection that are not currently part of the process and we haven't really talked about that. We've talked about analysis of information and we've talked about a panel. But we haven't talked about how do we generate new information that would actually be helpful in this process. I think that might be something to consider.

Recommendation one about the RUC composition makes me nervous on a couple of counts. Glenn, your characterization of it is a whole lot different than the language that's in the recommendation. I think if I were a lawyer I could think of a myriad of ways to implement the recommendation without necessarily changing the RUC in the

way that some may have in mind.

And so the question would be should our language be more explicit in terms of what we have in mind.

Given that, I guess I go to what should be the goal in terms of representation on the RUC? Kevin made a reference to the Senate model. I guess since we're in this context we have as the alternative the House model. Well, Delaware and Vermont still get one member each. So there's a question within the RUC of what kinds of membership do you need? What kinds of specialty representations do you have to have in order to make it an effective body?

It may not be in proportion to the Medicare service composition. There's the composition in terms of expertise. And I think we need to think about that.

The last point would be in terms of saying why we need to do this, I think the comparison of the 42 percent and the 30 percent, we need to look at the specialties that are the 30 percent, what share of E&M service, what their E&M services are of Medicare. Because other people in those other specialties that don't have the majority E&M are still providing E&M codes. So it's not quite a fair comparison.

We don't want to build a case that can be chipped

away.

MR. HACKBARTH: I just want to underline Bill's very first point about having a strong statement here, which I think goes to the CMS resource issue. Chronically we -- and I mean the whole system -- loses perspective on the allocation of resources. We chronically underfund CMS and then pay out huge sums of money based on inadequate information, inadequate data, inadequate analysis. That's a theme that we've mentioned in the past. I think this context is the place where we should once again pound that drum.

MS. BURKE: Let me begin by underscoring exactly what Glenn just finished with, and that is I think this is an opportunity for us to underscore once again garbage-in, garbage-out. That here, as in many cases, the quality of the information ultimately will either make us or break us. And we are shortsighted to essentially spend little in the way of gathering the information and evaluating it and then essentially spending it poorly based on bad data. So I think here again we have that opportunity to state it and we ought to state it absolutely clearly.

I want to agree with many of the points that Bill

has made. The overall theme in that, our desire to make sure that the payment system is fair and accurate, is the right theme. I am concerned that the structuring of the recommendations masks that just a touch.

I am also concerned to start with with recommendation one and whether or not we need to state explicitly what it is that we are trying to achieve. I worry any time we get into a percentage allocation of seats or anything else because the information can change, the impact can change. And it does mask the fact that there are a variety of people that are involved at a variety of levels. A straightforward 30 of this and 30 of that may not ultimately achieve what it is that we want.

So in trying to state our goal in terms of making sure that there is fair and appropriate representation, to make sure that the assessment is a fair one, I think is the goal. But I worry about not stating that clearly enough and then getting into one of these and one of those because I think that's really not ultimately what it is we're trying to achieve.

With respect to recommendation two, I think again it's linked to one, which is what you want is the right mix

of people with a broad range of expertise who can inform us on all aspects of this. I think there's some combination here in terms of how we gather that information. So I think we just may want to step back and think about what we're trying to say with both of those recommendations, in terms of both physician mix as well as additional information that we need.

Again, I think starting out by stating what it is we think we need in terms of getting the right information, based on having done the kind of research that Bill noted and Glenn noted as well, having provided enough resources.

Again, I think the point made about the combining of three and four, I am fundamentally -- well, I don't want to say fundamentally opposed.

I am very concerned about four because I think it leads to the kind of automatic behavior that doesn't necessarily reflect what we really want to do, which is to make sure that there is appropriate timely review of a broad range of things.

I think again the suggestion that whether it's a criteria under three, whether it is a note that needs to be they made that essentially more newly or recently introduced

relative values for new services ought to be reviewed on some frequent basis. As Bob suggests, that maybe within two years, it may be within five, it may be every two years.

And so to suggest that we automatically reduce relative values after a specific time would suggest that kind of knee-jerk reaction that again leads us back down the wrong path, which is that really the right kind of thoughtful review isn't occurring.

I think our point here is that there ought to be a review. There ought to be a fair process for determining what needs to be reviewed, whether it's a new procedure or one in which circumstances have radically changed. I just think we need to think about how we combine those and what the emphasis is that we specifically want to suggest.

Again it ties as well to five, which is we want to make sure it's valid. As Bill suggested, we want all the components looked at, not just one component, because all of them add into this sort of three-part calculation.

Again, I think it's three, four and five in some way reconfigured, so that we send the right message. I think the work that you've done here -- and like Glenn, I have learned a great over the last few meetings in hearing

about the RUC process works, its strengths and weaknesses. I think the comments made by folks that are here as well as the work done by the staff has been very, very helpful. I think we're going in the right direction but I think there are nuances here that need to be altered a little bit.

DR. NELSON: I generally support the recommendations.

I would like to have us acknowledge more explicitly the fact that there are factors that go into volume changes other than just mispricing. In the growth of imaging pricing is one of the factors but our intolerance of uncertainty if answers can be achieved safely, regardless of the cost consequence in many cases, is another factor. Neither American patients nor physicians like to watch and wait if there is a way to get an answer in the shorter term.

The growth of lab services is another example where obviously the volume is going up, although the prices haven't changed, because physicians are adhering to practice guidelines that call for doing laboratory services to track the diseases that are under discussion.

I think that four should stay as an independent recommendation but I think that it should be changed so that

the Secretary should automatically review and consider for possible reductions the work relative values for recently introduced services.

The reason for that is because even a couple of services that are arbitrarily reduced could be important. For example, the codes that were introduced for coordination and counseling. There is no justification for reducing those services when they already are not being adequately provided.

Another example is review of a home health plan. So those are situations in which an automatic reduction could be counterproductive.

I support the first draft recommendation without being too explicit in terms of composition. And I agree with Sheila's point about it being hazardous to arbitrarily start allocating slots or seats. In my view it makes more sense to have this general recommendation and allow the RUC itself to consider changes that it believes might make it better suited to do its job.

MR. HACKBARTH: On recommendation one, if you just read through the recommendations and you're not reading all the text, I'm concerned that some people may misinterpret --

not know whether recommendation one is talking about the RUC or the subsequent new panel that we refer to later. So as we work to the final version of the language, I think we need to be more clear.

DR. SCANLON: Or even the physician practice panel that exists.

DR. NELSON: If I could add onto that, Glenn, that's an observation that came to me. When I first read the recommendations, I wasn't sure whether we were talking about replacing the RUC or what the relationship would be between this recommendation and the second one.

So I think it -- in the first place, I think it would be a terrible mistake to replace the RUC if for no other reason -- and there are many reasons. But among them the fiscal note would be considerable because it involves a tremendous contribution of staff time and voluntary effort among the RUC and its advisory committees that if it were a governmental entity probably would have to be compensated in some fashion.

I think the relationship of the update committee and this other triage committee that I see as having focused responsibility on identifying possibly overvalued services

might be made a little more explicit, identifying them as having separate tasks to some degree, with the second committee having some sort of oversight responsibility that would be more proximally related to what CMS is doing.

DR. MILLER: [off microphone] Could you just give the last part one more pass at it? When you said oversight what you were thinking there. I just wasn't quite --

DR. NELSON: That probably wasn't the best word I could use, the first word, triage. There has to be some group who will pick up on overpriced services that the process has missed.

DR. MILLER: [off microphone] And you're seeing that as the second group?

DR. NELSON: Yes.

DR. MILLER: [off microphone] I think we're seeing it that way, too.

DR. CROSSON: One of the reasons that I think we took this topic up was the concern that was raised here, I think it was in September by Bob Berenson, about the passive devaluation of E&M services and the impact that that is already having, as a matter of fact, on physician manpower, particularly the flow of young physicians into primary care

services. I think then obviously the impact that that is having and can have in the future on access to primary care for beneficiaries. I think that even surpasses the equity issue that we were talking about earlier in terms of importance.

So as I looked at the recommendations, I think I generally support the direction of the recommendations. The concern I had was a question of whether they actually will go far enough fast enough to deal with the problem.

Dr. Rich, when he was here last month, said that in fact the RUC operates on a fact basis, as opposed to a political basis that was mentioned earlier. I think accepting that on its face, you're left with the problem that the rate of introduction of procedures and the relative higher cost of procedures compared with E&M services has the impact, as it has had already, of passively devaluing E&M services.

And I can't imagine that that's necessarily going to stop. I think the primary care physicians could potentially be more innovative in developing new ways to get paid under E&M services, but so far they haven't and I actually don't think that's the case. Whereas, technology

is developing more procedures all the time and they are expensive and becoming more so.

I guess the question I would have is again, are the recommendations going to solve the problem in a time frame that will materially impact on the problem that we identified in the beginning? And if not, is there some further analysis that we could do to look at, for example, ways to protect or to at least partially hold harmless the payment to E&M services within the construct of budget neutrality? Would that be something that we should look at for some further work?

MR. BERTKO: I'm going to follow some of Jay's comments up in a slightly different direction.

First I want to say thanks. A good report for educating us on the work of the RUC and the issue.

Mine is more along the lines of looking at the spending implications that you have built into all of these.

One is a prime implication, I completely agree, that budget neutrality moves it all around. But there could be a second implication, and there's some evidence at least in our under-65 population that in fact having more incentives to use primary care docs actually lowers the

costs. The number of office visits may stay the same but the average cost of an office visit actually is lower. Now this was from a different set of incentives so I guess I'm suggesting that you look for some evidence for this.

Secondly, on the basis of episode-based stuff, which I know a different group of you is doing, it's my perception -- although I don't have any facts -- that in fact when someone goes to a specialist they generally ring up a greater series of tests, procedures, higher cost procedures than if they had adequate treatment from a primary care.

To go along then, finally, with Jay's comment about the long term view of this, I think your staff work on access for new patients show that there is great access for a new patient to specialist but not quite as good access for primary care. I completely support Jay's comments about having longer term incentives to make sure primary care physicians are available to this population.

So my suggestion is perhaps no change with anything you uncovered might be turning to something that says possible reduction in costs from a variety of circumstances. And that would be another reason yet to do

this.

MR. SMITH: Carol, Dana and Kevin, thank you. Let me join my colleagues in saying how much I've learned over the last several months and I feel both more comfortable and much better informed than I did when we started down this road.

Let me talk briefly about each recommendation.

Glenn, I share your increased comfort with the RUC as a result of the process and the conversations. But I also a share Bill's unease with recommendation one. It suggests, and Bill used the right language I think, that there's some sort of underlying representative formula here which is the desired good.

Maybe there is but we don't know what that formula is, even if that would be the right way to go.

I'm much more concerned with the agenda of the RUC than I am with the composition of the RUC. In that sense I'm uneasy about recommendation one unless we can make it clear that we don't think there is some knowable bright line composition which is represented. I don't think that's what we want. To the extent that we're playing with a representative Senate model it seems to me we do want a

Senate model.

But in a zero sum game, which is an important piece of insurance here, setting the agenda is far and away more important than tinkering with the composition of the RUC at the bottom. So recommendations two, three and four -- and I disagree little bit with Bill on recommendation five in terms of its relative importance. But two, three and four seem key to me.

Sheila, you had expressed, I thought, some concern about two. It seems to me that one of the reasons that the RUC agenda is tilted in the wrong direction is that CMS doesn't have the resources to do its job and that this is explicitly aimed at that problem. And that seems to me to be right. This isn't an appropriate job for the RUC to do. It's a job for CMS to do, and to instruct the RUC as to where it would like to go. And some sort of committee of the kinds suggested in this recommendation seems to be right. And probably the job of that committee should incorporate recommendation three in following the statistical indications that something is amiss.

Four, it seems to me that what we know -- and Bob used the right analogy, I think, in thinking about the

manufacturing productivity curve. What we know is that we do get better at doing things the more and the longer that we do them. And that presumption ought to be built in to the relative value unit. When we adopt a new code, it seems to me, we ought to assume we're going to get better at it.

Alan, I think, offered a useful way out. Rather than get rid of recommendation four and put it into recommendation three as another possible trigger, that we would presume reduction but that the Secretary would be required to find or the commission would be required to find that there wasn't compelling evidence in the contrary.

So I think we can write this so that we presume improvement and we've got a bailout mechanism that doesn't require -- they can get triggered before the RUC has to itself find that we've screwed this one up.

So something along the lines of what Alan suggested, I think we ought to be able to work out that language.

On five, I am concerned about spending an enormous amount of money, Bill, on stuff that hasn't been reviewed and has a tiny presence. I don't know how to square that circle. It obviously would be good to make sure that

everything got reviewed over some period of time, but it does seem to me that given the very large size of the spending necessary to do everything else well that we don't want to mandate that a big chunk of that scarce resource get devoted to things where the consequences of the review could not be anything other than trivial because the spending in that area is trivial. I think we need to think about how to do that.

DR. SCANLON: I obviously would want to advocate an intelligent review, where you don't do the same thing for every procedure. I guess my concern would be about the idea that we're going to rely on analyses on this panel to identify all of the problems. I think that they're not going to be successful. There are going to be problems that are going to go undetected until we happen to look at potentially random samples at different points in time.

There can be levels of effort. If you're comfortable at one stage you don't go on to another, more expensive, stage.

MR. HACKBARTH: Could you put up recommendation four for a second? I just want to make sure that I understand what David is proposing.

What I heard you say, Dave, is that this would be the basic mechanism but the Secretary would have an opportunity to say these codes are excluded from that general rule, that we've concluded that this innovation curve does not apply to them. For example, perhaps some of the services Alan mentioned. And then the list goes on, edited.

MR. SMITH: [off microphone] The presumption would be a downsloping cost curve. And may be not even the Secretary to have the opportunity but the Secretary to have the obligation to consider whether or not a new code ought to be excluded.

DR. MILLER: I'm going to say this just a little bit differently, because we're going to have to get this down on paper.

Here's a way I could say back to you what I think you're saying, is if you preserve this assumption -- and I realize that other people have raised issues on it. But for the moment if you preserve this assumption, let's just say some of the other recommendations, we have this panel and this group that are supporting CMS's process. I'm going to give you a way of doing this.

That they develop information that says for any new set of codes that come out in any year -- and there's always a lot of them -- that they review that before it is forwarded to the RUC and say by the way, these of those codes will be subject to this, these of those codes will not be subject to it.

Do you see it going into the RUC or coming out of the RUC, is what I'm a little confused on?

MR. SMITH: [off microphone] I hadn't thought about it going into the RUC but I'm not sure that that doesn't work. Part of the problem though --

MS. BURKE: Mark, can you restate that because I'm not sure I understand what you said.

MR. SMITH: [off microphone] Mark, it seems to me that we want the providers of the service that is slated to go down the cost reduction path to have an opportunity to say to perhaps this panel oh no, it's inappropriate in this case. In a couple of examples that Alan mentioned, and there will be others, that a third task for this new committee could be to advise the Secretary of which new codes ought to be exempt from the presumption.

DR. NELSON: My words were should automatically

review and consider for reduction. But this would be after the RUC had finished its process and we'll say six months or one year after the code has been approved and paid. Then it would be automatically reviewed.

MR. HACKBARTH: This could well have been written by a lawyer. This is all about shifting the burden of proof, which often is dispositive in these things.

As I understood the original recommendation, it would provide the opportunity for the affected specialty to come in and present data to show that no, this general rule does not apply. And so that was built into my understanding of this.

What I thought I heard you initially say, and this is why I asked for the clarification, that you were creating a second opportunity for the Secretary or the Secretary's advisory panel or whoever to edit the list before it even went to the RUC.

MR. SMITH: [off microphone] No. I think both Alan and I were the back end of the RUC process rather than the front.

MS. BURKE: I'm sorry. So what you're -- let me just ask a fundamental question.

As I understand this recommendation, it is a presumption. It is an automatic event that occurs absent an intervention.

So let me ask the basic question. Are you and Alan opposed to the automatic reduction? Alan is.

So Alan and I are in the same place about not wanting the automatic nature of it to occur. Rather a review should occur but not the presumption that it would -- it is this question of where the intervention occurs. In this case, you have to prevent it from occurring.

You and I are suggesting a review occur, but that there not be an automatic reduction absent a second review that said this needs to be done. I think there's a fundamental -- and David, you're on the side of --

MR. SMITH: Sheila, where I am is that there is a rebuttable presumption that the reduction should occur. So that the RUC is assigned a relative value to a new code. It is slated to automatically move down a cost curve. But any affected party can go, presumably to this new committee that's described in recommendation two, and say there's compelling and good reason why this shouldn't happen.

MS. BURKE: [off microphone] But you're

comfortable with the system that would have it automatically occur.

DR. NELSON: You can't consider whether the work has changed until it's been implemented, until it's been in operation for a while. So you can't do it at the front end of the RUC. It has to be a service that has become -- that is now being paid for and has become used. And then after some period of time you look to see whether the work has changed.

DR. REISCHAUER: But we're acting like there's one cost function for all conceivable new codes. And I think that's crazy. I would assume that you might have six or seven variants of this and you'd apply them. And one of them would be flat. You'd assume there would be no reduction.

MR. SMITH: [off microphone] Who would apply them when?

DR. REISCHAUER: I think the second commission might select one to apply to each new code at the start. But one option would be no expected reduction at all because of the nature of whatever is it that we're talking about here. These codes are all over the line, the new codes.

MS. BURKE: So Bob, your suggestion, let me make sure I understand. Your suggestion would be at the point of the service being included, that a decision would be made by a third party that would suggest that this is one that should not automatically go down but ought to be under the following review schedule? That that would be made proactively at the point of including the service. This, in fact, would not be the case for some.

So the suggestion is that this third party, whether the RUC or someone else, would make a proactive decision that there are certain services that are reviewed -- there are certain services that are automatically reduced but for an intervention. There are services that go into a review of some time line at some point.

But similarly, all of the things that are already in the code would also be under some time line. Not just a five-year time line, but some newly revised time line that takes into account new information about the frequency with which it should occur.

I'm trying to understand all of these moving parts and we're into about 12 sets of rules here.

DR. MILLER: Let me try and capture this

conversation.

I still think there is some disagreement around the table here, so I'm not trying to articulate a position, just something to shoot it.

MR. HACKBARTH: You got that part right. You're off to a good start.

DR. MILLER: Let's articulate a process here. This is now different than what we had up here.

so the process would work like this -- and it's kind of back to what I was saying, because I think there's a couple of things going on here.

First of all, I think it's important to track on for the most part -- not for the most part. We've been talking about new services here. New services that come in. This connects to many comments that people have been making, most recently, in my mind, Jay's comments that there's lots of stuff that comes in. So these new services show up.

A way that this could work is CMS, as supported by this new panel and this new data analysis that they're doing, et cetera, could look at that list. And to address the point that Bob is definitely making and it sounded at times like David was making, would be to say all these

services aren't the same. This is a high piece of technology that is going to disseminate fast. People are going to learn how to use it. This baby is going to drop.

This is some other service, which I can't give you a good example this second, like Alan's example, that isn't. So that would move to the RUC.

Here's the $64,000 question, and now we're more back to what we put on the board to start the conversation.

They enter the RUC and you could think about this two ways. They have an automatic path that drops unless evidence is presented to the contrary. And the RUC considers that. No, I'm telling you this technology is different and it's not falling the way you're assuming or it is. And it sort of shifts the burden of proof.

And my last comment is the other way you could do that mechanism is to say it just triggers a review. It doesn't have an automatic downward path.

I think those are the parameters that everybody's kind of talking about.

MS. BURKE: I have to sort of visualize this. If you visualize it -- I wish I had the little board thing.

If you visualize here are categories, these are

new procedures. And here is the category of current procedures. Next the current procedures is a five-year review that has currently in place. Then there are these new things. And you have these two sort of strategies that you can employ for the new.

The concern that I see is the automatic nature of certain activities. But there are questions about things that are coming in that we will gain experience from, and the issues that Alan raises as to whether or not we have an expectation of certain things occurring.

And then there is the ongoing process for the current RUC, the current procedures that are in place. What I think we need to step back and think about is what overall is the combined procedure? What is the overall process, both for the things that are coming in new as well as for the things that are already in place.

Because some of the issues that arose in the context of the paper are not just for things that are introduced that are new but what occurs in the normal review process that has things either increasing or decreasing and the subsidiary effects when essentially you're in a budget neutral environment. In which case things sometimes

decrease not because you specifically went after them, because essentially you had to make these decisions.

We have touched on a couple of those things but overall there is this broader problem about what the valuation of services is based on the knowledge that we have and whether there are unintended consequences that occur because of changes to certain things and not others.

And so we've spent some of this morning talking only about the sort of things that are introduced new and whether there ought to be a new method for determining whether they go under review.

I am equally as concerned about what the process is for the current and the unintended consequences that move things around.

MR. MULLER: Why doesn't three capture that, Sheila? Doesn't three capture that?

MR. SMITH: You're getting into CMS's job.

MS. BURKE: My concern is that we're separating these things out, where I think what we ought to be looking at is the overall process, and decide what happens over time.

MR. MULLER: I would think maybe we can amend

three a little bit. My initial suggestion by saying let's fold four into three was to say well, the presumption of some new things -- maybe minimally invasive surgery 10 or 12 years ago, bariatric surgery in the last eight years has grown a lot and so forth.

But if we're looking at the overall valuation of procedures, and going to many of the points that Alan and Jay and others have made, it may be -- just to quote words here -- it may be sites of service, it may be volume. There are a set of different triggers. And so I would say those are the things that allow us to decide which of these many procedures and values we look at.

I think one can answer that question to make the new ones one of the triggered reviews under three, one can then, as a secondary point, get into Bob's curve and decide -- I see that as a secondary issue as to whether there are kind of different time periods for different ones.

But I would suggest that therefore -- and we may want it listed as the first of these lists after triggers and so forth, as a way of putting weight to it. Or I would say certainly, given our discussion over the last few years, that the volume trigger is one of great importance because

that would capture, for example, the imaging one.

MS. BURKE: Let me ask the basic question. what is the presumption on the part of the staff or our presumption with respect to the current five-year review? Do we leave it in place? Do we change it? Does it get altered by the information that we're gathering here? What is our stated intention with that, as compared to a new review process, as compared to an automatic process?

DR. HAYES: With respect to the five-year review, the presumption was that we would keep the process in place but we would do a better job of identifying what services need to go into through that process. Right now it's largely a process of physician specialty societies identifying --

MS. BURKE: Right, I understand that.

DR. HAYES: So we would use some of these tools, these data oriented tools here.

MS. BURKE: So that recommendation three is to influence the decisions on the five-year review? So we're assuming five years is the right number?

DR. HAYES: Yes. Only because that's what historically has been the practice and because that's what's

in the law.

MS. BURKE: But it seems to me if we're suggesting a whole new process we ought to look at the fundamental question is a five-year review the right answer? Is this supposed to suggest -- when you say should institute automatic reviews of services that have experienced -- what if they've experienced in two years or in three years or in the first year? Do we want to leave in place five years because that's what we think is the right policy?

DR. MILLER: That's kind of what brought us to the automatic and the discussion of new types of services. In a sense we were saying -- and this is what you're taking on, but I just want to articulate it.

So you have these existing services. They move from five to five -- and of course there is annual work that goes on. But they move from five to five. And this says things are happening here that really raise questions about it.

Meanwhile, you have all these new codes and this process that we sort of sorted through of does it have a falling trajectory, would apply to these new codes. And of course, all codes or any set of codes that people think is

reasonable to review, would be brought into the five-year review.

So you'd have the existing sort of hitting five-year reviews, new ones being looked at with either these automatic or not so automatic drop-off, however we decide. And then everything hitting the five-year review based on information that suggests is needs to be reviewed.

MS. BURKE: So the adjustment occurs in the course of five years. Under this scenario if you have a new thing that has occurred and the decision is either automatic that in two years something happens or whenever.

So in between the five years you're also doing interim adjustments to those but having no impact on anything else?

DR. MILLER: [off microphone] To new services.

MS. BURKE: To new services.

MR. HACKBARTH: I've got to cut this off. We're behind schedule and I think we've gone over the point where we're -- we're past the point of diminishing returns right now.

I think we've got some issues framed and some concepts. I think that Sheila's idea of drawing some

pictures here, sort of flow diagrams to describe different options, may help us get together.

We do have four people who have been waiting patiently. And I want to give them a chance to talk before we move on.

MR. DURENBERGER: Thanks.

I wanted to start by complimenting the staff, and I mean the staff in general. We were visiting before the staff showed up in somebody said well, we should have five people here this morning. And I think we had closer to 30 off the Hill. And Mark and Glenn and everybody else on the staff, it's a compliment to you, that all those people showed up. Many of us had the opportunity to listen to what they were saying.

Among the things that they talked about, and I like what Bill said about intelligent review rather than intelligent design. This seemed like an intelligent review until a couple of minutes ago, as opposed to intelligent design.

But Sheila is getting us at the intelligent design thing, just as she did back in 1989 when we --

[Laughter.]

MR. DURENBERGER: I know it doesn't sound like it. I know it didn't sound like it.

MS. BURKE: Please do not go there on intelligent design.

MR. DURENBERGER: The reality is, from where I from, listening to these people talk about our biggest problem is volume and our solution is pay for performance but we don't know what the hell it is, please tell us, really gets me focused on this whole work that we started -- while we may have started it on the RUC or whatever it is -- the way it's now evolving. We know physicians drive 87 percent of the money in the system. And driving this system towards real value is critically important.

We did the best we could in the intelligent design stage. And in the intelligent design stage you have to accommodate the politics. And in those days it was either the AMA politics or specialty politics or whatever. So you accommodate, in determining what is relative value not just for work but for everything, to your politics.

And basically that was given to what is now called the RUC. And that's where the five-year analysis and everything comes out of.

What I think we are trying to say here is that five years and organized medicine shouldn't drive decisionmaking. Information should drive decisionmaking. And that's why the importance of this second recommendation, and thinking of it not as another commission or whatever it is. Information needs to drive decisionmaking on the part of third-party payers, on the part of Medicare, on the part of physicians themselves. The medical education enterprise needs to be driven by this kind of information.

So I wanted to underscore, and in response to where Sheila was at right at the conclusion here, I'm for dropping the five years. I'm for dropping all the intricate detail of the processing and focusing our recommendations and whatever we want to say about process on the critical importance of information driving decisionmaking, not 23 representatives of organized medicine, in the absence of any other effort by CMS or whatever, driving decisionmaking. I think that's the important contribution we're making.

The only added thing is that MedPAC should never give up on being involved in that process because we do as good a job as CMS or anybody in this place of developing the information, asking the question that should be driving

this. So that doesn't have to be in a formal recommendation but I think we need to say that to ourselves because of the importance of what lies behind this relative value discussion, that this is a very important investment as an advisory board to Congress we need to make.

DR. MILSTEIN: Previously commissioners have discussed and been somewhat self-critical about whether or not some of our individual decisions in narrow policy silos are really adequately interfaced in terms of our broader objectives. I think this set of decisions is a very nice case in point.

Let me just move this into two practical directions, one in relation to recommendation number two and the other perhaps in the direction of recommendation number six, which I realize is TBD.

Number two, if our aspirations are both to significantly improve the quality of care the beneficiaries are receiving, and also to provide some advice that promotes the sustainability of the Medicare program, I wonder if we might consider adding onto the task of our review panel, this second wave review panel, whatever its name may be, the bringing to bear in the relative weighting of physician

codes cost-effectiveness, particularly as it pertains to the 20 percent of services for which we do have cost-effectiveness information.

One of the observations that Peter Neumann and David Eddy made when they came to talk to us about this last spring is that yes, it's true, we don't have information on either cost-effectiveness or both for 80 percent of what we're currently spending Medicaid money for.

But for 20 percent of services we do have information. And there is a subset of those 20 percent of services that have a very, very favorable profile of quality delivered to Medicare beneficiaries relative to what it costs.

A case in point would be smoking cessation counseling. Currently it's not something for which any kind of adequate payment is made. And as a result, it doesn't happen very much. And as a result, both the quality and the affordability benefits of the Medicare program are being lost.

And so my first suggestion is that we consider adding to the scope of responsibility of this second wave panel the potential incremental weighting of those subset of

Medicare coverage services for which there is evidence of a uniquely favorable relationship between health gain and dollars spent.

Second point relates to my reference having to do with recommendation six. Really I think it builds on Jay's point about the current equilibrium, which I would agree with Jay. I would describe it as a rapidly eroding financial viability of high quality primary care. And especially within primary care something that Alan has frequently referenced, and I think in some ways Nick's organization and Jay's organization exemplify, which is physicians taking longitudinal accountability for quality of care and care coordination. It's currently nowhere to be found in the fee schedule. It's an absence that people have commented on for probably at least 15 years but for which no remedy is yet at hand.

And so I guess what I'm asking is that Commissioners consider and the staff consider whether or not as part of this set of recommendations, and in keeping with Jay's comment about we have a serious problem that is pretty far down the tracks. If we want to have a hope of reversing it we have to make sure that the medicine that we're

introducing is strong enough, whether or not we ask that the Secretary establish an E&M code that pertains to physicians taking accountability for -- primary care physicians usually -- taking accountability for coordinating all services that a beneficiary is receiving. It's obviously not every physicians' cup of tea. But for the physicians that are willing to step up to the plate, take that accountability, is it not time to establish and pay for that code in order to, among other things, make the practice of longitudinally accountable primary care more financially viable?

MR. HACKBARTH: Let me just pursue that for a second to get some clarity, at least in my mind.

Jay framed the issue a little bit differently, at least to my ear. And I'm putting words in Jay's mouth.

It may be what you want to do is that for a range of primary care services have an additional conversion factor and add on to the conversion factor. Because as a policy matter we want to encourage good primary care. We want to make it a financially viable thing. We want to make it an attractive area of practice for physicians in training.

I hear you saying something that's not necessarily

inconsistent with that, but it's a different approach, which is to say a code for rewarding a particular activity.

DR. MILSTEIN: May I clarify my suggestion? First of all, I support Jay's recommendation. It's directionally excellent.

But I was trying to make the distinction between paying primary care physicians more for each individual visit. That, to me, is different than paying primary physicians more for stepping up and taking accountability for longitudinal care coordination along the lines of what Alan has previously described the best primary care physicians in America already do but aren't being paid for it.

MR. HACKBARTH: What I was trying to get at is so you see them not as inconsistent. You would favor both?

DR. MILSTEIN: Yes.

DR. CROSSON: Yes. And I didn't come ready to write the regulations this morning.

But I was primarily getting at the fact that I think the flow of new procedures and the flow of dollars into them, because they're so expensive, is having an impact on the payment for E&M services. And that some mechanism --

this could be, for example, creating a hold harmless pool within budget neutrality within the RUC for E&M services, or some other mechanism which would have the same effect on neutralizing all or some of that disproportionate flow of dollars over time would be a good idea.

MR. HACKBARTH: I really want to get to Nick and Ray, but please bear with me.

One of the factual questions that I need sorted out for me is the extent of passive devaluation of primary care over the history of the RBRVS system.

If I interpret the data that we've seen, I don't see a whole lot of passive devaluation. I see some increase in the relative values and some loss on the volume side. But the primary care share of the total dollars going out has gone down. But it's not like it's fallen off a cliff. That's something I just need to get straight in my own head.

The premise of your formulation is that's what we're trying to counteract, is that passive devaluation.

A whole different approach is not to tie it to that and just say as a policy matter we need more good primary care in America and we went to increase the relative payment rate. It's separate from the RUC process. The RUC

process is never going to produce it.

DR. REISCHAUER: We don't pay for things that way. I mean, the whole RUC process. We should but that's like re-thinking absolutely everything.

MR. HACKBARTH: That's what he's raising.

DR. HAYES: One way to deal with this would be to consider the spending figures that we cited on page four of the mailing materials, which shows that the portion of spending went up from 36.5 percent in 1992 to 42.2 percent in 2004.

MR. HACKBARTH: What's the '92 number? If we want a longer-term perspective on that? This is just two years. What I want to know is over the course of RBRVS how many passive devaluation -- if we go back to 1992.

DR. HAYES: On page four we have spending figures. 36.5 percent --

MR. HACKBARTH: Oh, I'm looking at the wrong page four. That's my problem.

DR. HAYES: We have 36.5 percent of spending went to E&M services in 1992. That went up to 42.2 percent in 2002. And then later on we talked about how spending for E&M services has started to --

MR. HACKBARTH: It went down to 40.7.

DR. HAYES: Down to 40.7.

The point to make here might be along the lines of the following: yes, it could be that 2002 was kind of a peak year because that was the year when the resource-based practice expense RVUs were fully phased in. So we had an increase in payment rates for E&M services in that year.

Now what we're faced is is a situation where growth in other sectors, other parts of the payment system, imaging and tests let's say, they continue to go up. E&M is kind of where it is. The fee schedule is kind of fully phased in. And we could be looking at a situation where it's just going to continue to fall off. And that would be the passive devaluation that we talked about.

MR. HACKBARTH: It's a relatively new phenomenon. We actually went up in primary share or E&M share and now that curve is tipped downward. You're saying it may well continue down.

DR. KANE: To what extent is that just the physician work piece and to what extent is the practice expense contributing to that, too? Because that was the part I remember really greatly having a big effect on E&M

relative to others.

DR. HAYES: If we look over the whole span from 1992 through 2002 or 2004, it was a combined effect of changes in RVUs for work. They were reviewed during the first five-year review and experienced an increase. And then there was a transition to resource-based practice expense RVUs, which was completed in 2002. So it was kind of a combined effect.

DR. KANE: Would the devaluation also have a combined effect? Because aren't practice expense RVUs also reevaluated every so often?

DR. HAYES: Yes. They are subject to a five-year review process just as -- starting now.

DR. KANE: So maybe we have a problem on both sides of the -- maybe it's not just -- mostly we've been focusing on the work component and I'm just wondering if the practice component is also going to contribute to a shift that may or may not be the direction you want.

DR. MILLER: Just to remind you, we've also gone through what our agenda is for the physician fee schedule broadly, which has been driven by many comments from many Commissioners. And we do have an explicit set of work that

we're thinking about on the practice expense. This was a part of our focus on the work piece of it.

But you are right, there are two different components. We do have other sets of work aimed at that.

DR. MILSTEIN: Can I ask a follow-up question?

So far the dialogue on our basis of evidence has been E&M codes. But what Jay is referring to and what I was referring to is E&M codes for primary care. Do we have a clear signal of that phenomenon, given that that's the topic that we're trying to resolve?

DR. HAYES: We can put that together for you. It's about 20 percent of spending. Your question, I think, is how has that share been changing over time?

DR. MILSTEIN: Yes.

DR. HAYES: Sure, we can do that.

MR. HACKBARTH: Good point, Arnie.

DR. SCANLON: On that, as we've been talking about this passive devaluation of primary care or E&M codes due to the introduction of the new procedures, there's another phenomenon that goes on in the fee schedule and that is the averaging effect. The averaging effect, in terms of practice expense and malpractice, actually takes money from

some higher priced specialties and puts it into primary care physicians because the allocation of their E&M code expenses is put into a pool and averaged. And so some people, the money they're getting for malpractice for an E&M code is less than what their actual malpractice costs are.

This is a phenomenon that has gotten clearly more relevant in the last few years as we've had very large increases in malpractice costs, as well as differences across specialties. That's something else that's going on here. There's a lot of distortions in this fee schedule.

DR. CROSSON: Glenn, just one more point on the practice expense piece.

I believe last month we also saw, if I remember correctly, that there were only 12 specialty organizations who had applied for the opportunity to review the practice expense piece. As I remember them, they were all procedure-based specialties.

MR. HACKBARTH: Okay. Having delayed Nick and Ray this long, everybody else including me has to turn off their microphone and they can speak without limit.

DR. WOLTER: I don't think I'll take you up on that offer.

I think draft recommendation two is potentially very important. What I remember from last month and then some of the conversation this month, I think there's an interest that that panel take on the issues around physician payment in a strategic way. And whether that be primary care needs or geriatric or mental health. We all have things that we put on the list that may be right now there's not a place in the system where that kind of strategic thinking is going on.

The recommendation seems a bit narrow to reviewing RVUs. And the text also doesn't pick up much about that more strategic or potentially strategic role for this panel. So I just raise that as a question, do we want to include that in the text and maybe more so in the recommendation itself?

MR. HACKBARTH: That would go in Jay's direction, be compatible.

DR. WOLTER: Yes.

One other thing I would just say, I know you wanted to stop on this. But number four really doesn't make sense to me. I think Bob said it right. There may be different cost paths for different services. Some would go

down, maybe most. Some might stay flat. You might even thing of a few that could go the other direction.

It would make a lot of sense to have new services be one of the triggers for review. But it's hard for me to predict or feel like I have the expertise to suggest that they would all automatically go down.

So just from for my point of view on that one.

MR. HACKBARTH: So your view is similar to Ralph's on that.

DR. STOWERS: I'll also be brief.

I just wanted to get back to what Jay said earlier, about what kind of brought us to the table was the discrepancy of physician reimbursement and not just the codes and that kind of thing.

It's a great chapter. And just one point I want to make is that I think we've all come to the realization that it's RUC's responsibility to give us unbiased analytical values of the codes that we're dealing with. But the RUC itself is not and cannot be totally responsible for the outcome in physician income differences.

And I don't think that recommendation two is either going to settle that either because they're going to

serve a function in working with the RUC and identifying codes and that kind of thing.

And many times RUC has tried to do the right thing in providing values and the existence of codes for oversight management, recognizing the need for chronic care management in Medicare and so forth. But CMS chose not to pay for that.

So I think where I'm coming around to is that we need to be looking, I think, somewhere in Sheila's diagram as who in the system is going to be responsible for taking an overall look at physician income? And I think one of the most fun parts for me, back on the Physician Payment Review Commission, was that we did and we looked at all of the factors involved in discrepancy and access to care through proper specialty mix and that kind of thing.

So as I think Dave hinted a while ago, I think the MedPAC would be a great place to have that happen. But I think someone in the system needs to latch onto that responsibility and take that on. I think I'm hearing that starting to happen here. So I think it's a good phenomenon.

MR. HACKBARTH: Okay, thank you very much.

I'm sorry, Jennie.

MS. HANSEN: I just wanted to lend my voice to that side of the table to talk about the role of MedPAC reframing the primary care piece and looking at the episode longitudinal aspect of it. So I think this is an important discussion.

And if the transitional aspect is to increase the E&M for primary care, that might be an interim measure. But to really put a bookmark to really the longer range discussion, to certainly get going into primary care, realizing where med students are going.

My son just graduated from med school and I certainly see -- and he's gone on the side of proceduralists as an orthopedic surgeon. But here we're thinking about practitioners -- sorry. But for the next 30 or 35 years we really need to make sure there's going to be an ample supply of primary care for people with comorbidities.

MR. HACKBARTH: Thanks.

Cristina is doing our next presentation, which is on payment adequacy for physicians.

MS. BOCCUTI: This morning I'll be presenting an assessment of payment adequacy for physician services. First I'll go over two indicators in this assessment that

you haven't seen yet. Those are specifically service volume and ambulatory care quality. Then I'll review findings you saw just a few weeks ago at our November meeting, beneficiary access to physicians and physician supply. Then I'll discuss expected cost changes for 2007.

In our payment adequacy we look at changes in the use of services by Medicare beneficiaries. As we look at claims data through 2004 we do not see decreases in volumes, at least among broad categories of services shown in this chart. Rather, across all services per capita volume grew about 6 percent between 2003 and 2004. So this growth, as you know, includes increases for service intensity as well as units.

Looking across the years you see that imaging continues to have a high growth rate. In 2004, 11 percent per beneficiary. For the first time the volume of the other procedures categories grew more than tests, but both were pretty similar. Other procedures grew 9.3 percent per beneficiary, and tests 8.9 percent.

The other procedures category includes the subcategory called minor procedures. That category grew the fastest in 2004. Physical therapy codes had the greatest

volume increase in this category. Drug administration codes grew as well, some of which may be due to the new ability for physicians to bill multiple times for chemotherapy administration in a day.

Overall, we saw a couple of instances of volume decreases which can be explained by general trends in practice.

So the cumulative impact of these annual increases in volume is shown by the dark, upwardly sloping line that you see on that chart. So as you know, these increases have resulted in substantial increases in Part B spending. In 2004 alone CMS recently estimated that spending on physician services increased by about 13 percent. Using information supplied by the AMA, CMS has noted that although some of these volume increases are related to improvements in health care quality, much of the increases cannot easily be explained by changes in new medical evidence and technologies.

For this year's payment adequacy analysis we begin to examine the quality of ambulatory care through Medicare claims data. For our analysis we used a new claims-based measure set which we're calling MACIEs, which is the

Medicare ambulatory care indicators for the elderly. Because this analysis is new I'm going to take a moment to give you just a little bit of background on the measure set.

MACIEs are derived from the ACE-PROs which were developed nearly 10 years ago by a research team at RAND for our predecessor, PPRC, the Physician Payment Review Commission. Last spring we convened an expert panel of physicians, clinicians, and researchers to review and update the original indicators to reflect current basic clinical standards of care.

The MACIEs focus on two types of measures, the percentage of beneficiaries who received clinically necessary services for their diagnoses, and the percentage who had potentially avoidable hospitalizations directly related to their diagnoses. Because the MACIEs are based on claims data they're a resource efficient method to monitor potential underuse. But they, of course, cannot account for reasons why patients do not receive necessary care.

For purposes of our update analysis we're tracking these quality indicators in the aggregate. Further analysis can compare MACIEs for specified subpopulations.

On to the results. I'll take you through this

table here. The table tracks changes between 2002 and 2004. The numbers in the table refer to the number of indicators within each medical condition that showed improvement, no change -- we'll call that stable -- or worsened. The medical conditions are listed at the top. The cancer category includes breast cancer and colon cancer.

As you can see, most of the indicators we measured were steady or showed small improvements between 2002 and 2004. Among 38 measures, 22 showed improvement and 13 were stable. This suggests that beneficiaries with selected conditions were a little more likely to receive certain necessary services for their condition and averted potentially avoidable hospitalizations in 2004 compared to 2002.

In only three out of 38 conditions did we find a decline in quality as defined by our measures. All three were related to breast cancer. We found small declines in general mammography screening for females and clinically indicated imaging for women with a history of, or a new diagnosis of breast cancer. These slight declines are consistent with ones recently found by NCQA for health plans reporting HEDIS data.

There's a couple more findings that I want to mention on this analysis that aren't specifically indicated on that table. We found that for several conditions declines in potentially avoidable hospitalizations occur concurrently with increases in the use of clinically necessary services, or you could call them process measures, for that same condition. So in taking diabetes as an example, we saw lower rates of short and long-term complications such as diabetic coma and non-traumatic amputation concurrent with higher rates of necessary care such as lipid and hemoglobin testing.

In addition, we also looked at the number of categories where the share of beneficiaries getting the needed service was at least two-thirds of that share. We found that in 20 out of the 32 measures for necessary care at least two-thirds of beneficiaries receive indicated care for their condition. That was in 2004 we took that measure.

In November I presented some findings on beneficiary surveys on access to physician services, so I'm just going to review that very briefly. The majority of beneficiaries reported little or no problems scheduling appointments and accessing physicians. A small share of

beneficiaries, however, reported having problems, particularly those who are transitioning beneficiaries such as those who have recently moved to an area or switched to Medicare fee-for-service.

Medicare beneficiaries, we also found that they had similar access to those that are privately insured age 50 to 64. Large surveys show that access was generally stable between 2003 and 2004.

We also examined a physician survey regarding the proportion of physicians who are accepting new Medicare patients. In general the most recently available data indicate that most physicians are willing to accept new Medicare beneficiaries. That comes from NAMCS, the national ambulatory medical care survey. Results from that survey show that 96 percent of office-based physicians had open practices in 2004. That is, they accepted some new patients. In 2004, 94 percent of physicians with at least 10 percent of their practice revenues coming from Medicare accepted new Medicare patients. These rates are very similar to the ones in 2003, no statistical change.

Still reviewing, our claims analysis from Chris Hogan showed that the difference between Medicare and

private fees has steadied over the last several years. We saw a slight narrowing in 2004. The analysis is averaged across all types of services and areas. So as you know, the difference between Medicare and private fees varies considerably by type of service and geographic area.

Keeping that in mind, research by the Center for Studying Health Systems Change has found that in areas where Medicare fees are closer to private fees beneficiary access wasn't measurably better than in areas where the fee differential is much greater. This suggests that there are other factors such as local health system developments that may influence beneficiary access as much or more than Medicare payment levels.

At the last meeting I showed you an analysis of the number of physicians per Medicare beneficiaries. Ray asked that I look at the supply of physicians with caseloads greater than 15, so I'm just showing you here the result of the sensitivity analysis to that effect. The table shows the number of physicians per 1,000 beneficiaries by their Medicare caseload. You can see that on the top column headers. That's the caseload. So the 15 plus is 15 or more Medicare beneficiaries that the physician saw.

So in this table you see that the rate increases in all categories between 1999 and 2004. Interestingly, when we looked at the raw numbers behind these ratios we saw two additional findings that I want to mention. First, we saw that a little more than half of the physicians billing Medicare had caseloads of at least 200 Medicare patients, and that the higher the caseload threshold, so when you got to the 200 or more Medicare beneficiaries, the faster the growth rate from 1999 to 2004.

MR. HACKBARTH: When you say the faster the growth rate, you're saying the faster the increase in the ratio of physicians to their Medicare population?

MS. BOCCUTI: Right. Not necessarily the ratio. We saw the ratio on that slide. What's faster is the number, the growth in the actual number of physicians grew faster the higher their caseload. Does that make sense?

MR. HACKBARTH: That should show up in the ratio. So the ratio has increased faster in the 200-plus --

MS. BOCCUTI: Right, the ratio grew. They're directly derived from each other so you could say both grew.

So then I'll just go on to the second part of the adequacy framework, which is the changes in costs for 2007.

The preliminary forecast for input price inflation is an increase of 3.6 percent, as provided in CMS's Medicare Economic Index -- that's the MEI. As you know, within this total CMS sorts the specified inputs into two major categories, physician work and physician practice expense. Physician work, that includes salaries and fringe benefits allotted for physicians which is an expected to increase by 3.6 percent. In the physician practice expense category we have non-physician employee compensation, office expenses, drugs and supply, medical equipment and PLI, which is forecast to increase by 8.6 percent.

Some physicians, as you know, report PLI premium increases that are much higher than what is forecasted in the MEI. For example, physicians practicing in certain geographic areas such as Detroit and those whose specialty includes high-risk procedures such as neurosurgeons. They report PLI costs that are much higher. But recall, however, that the fee schedule is Medicare's primary tool for capturing this variation. It reimburses services differentially to account for PLI by service and geographic area. The MEI is used as a measure to forecast a change in input costs across all physicians.

Lastly on that slide the productivity factor, we also consider that in our input cost analysis. Our analysis of trends and multifactor productivity suggests a goal of 0.9 percent.

So in sum, the indicators I reviewed today do not suggest a payment adequacy problem for physician services. I'll be happy to take questions and comments.

MR. HACKBARTH: Time is short here so I'm going to try to cut to the chase a bit. The way I'm going to try to do that is I'd like to pose to the group a question that I often hear from people on the Hill about this issue.

Let me start with a couple points. First of all, we are in the awkward position of trying to think about an update for 2007 when we don't know what the update is going to be for 2006. And making that more difficult is that there's a fairly wide range of possibilities still on the table, so to speak, for 2006, anywhere from a 4.4 percent cut to a 1 percent increase. It just boggles my mind to even think about how you can recommend a number for 2007 when you don't know that. So that's point number one.

Point number two, and this is getting to what I hear from the Hill and I need help wrestling with. You look

at our measures of payment adequacy for physicians and as a group they are more useful in identifying underpayment than overpayment. The one exception, I guess might be the relative price, the comparison of Medicare fees to private fees. But the others focus on access and they're going to give you a sign when payments are too low but not too high.

Point number two is that the update recommendations produced by MedPAC using our basic starting point of MEI minus productivity have in recent years produced updates that are consistently, in an aggregate, significantly higher than those that have come out of Congress and the physicians have received. In fact this is the only area I think where that's the case.

So what I hear from people involved in this process on the Hill is we've consistently done less than you've recommended yet you tell us that there is no discernible broad negative effect on access. Is MedPAC recommending updates that are too high for physicians, especially in view of the one-dimensional, one-directional measures that you use to set your recommendation?

That's a real world question that we get asked and I wanted to present to the group and get some reactions to

it.

DR. KANE: One thing that struck me is that volume in all the other services we looked at, rising volume meant we were paying adequately. On the physician service side we are now interpreting that rising volume means we're not paying adequately because people are trying to make up for low payment rates with higher volume. Whereas in all the other services we looked at we interpreted volume exactly the reverse.

So I'm just wondering if we have a little problem of figuring out what by volume means with respect to access and the payment rate adequacy.

MR. HACKBARTH: I think we do and we are not alone. This has been a longtime problem. The fact of the matter is that there are multiple sources. Alan, I think made this point earlier. There are a lot of different forces that affect volume trends, some having to do with medical practice and technology and good services that we want patients to have. Others might be an undesirable response to fee constraint. It's very difficult to characterize these trends in the aggregate.

DR. KANE: I think that's the problem. The SGR

very clearly says, volume going up is bad and suggests you're -- but we've interpreted that as volume going up means we're not paying enough and therefore they're trying to make up the same income with the volume. Whereas, in all the other services we've looked at we interpret it exactly the opposite. So I'm getting a little confused myself as to what do we mean when we're looking at payment rates. What really makes us think a payment is adequate or not? In physician fees we're saying volume increases means the payment rates are too low.

MR. SMITH: Nancy, actually I think we've been speculating and not something slightly more complicated. We've been wondering whether or not physicians think income is too low and therefore have increased volume. But what we haven't used the volume increase as an argument for something other than a cost-based, a cost minus productivity based recommendation. We haven't said, we've got an access problem here that we need to respond to with and out of cycle update. We haven't said that, although some of us have intuited, don't know whether or not correctly or not, that the volume spike has something to do with physicians' belief that income is inadequate regardless of the Medicare

fee schedule.

Glenn, let me come back to your initial question. There wasn't a recommendation in front of us. It seemed to be entirely appropriate that there shouldn't be. We often feel like we're in a Kabuki play, but making a recommendation for a 2007 fee schedule update without knowing what's going to happen for 2006 would really make us feel like we'd stepped out of a Japanese pageant so I think that makes sense.

I get the same question you get a lot. We all do. One of the problems is that it's only definitively answerable if we conduct a natural experiment that we don't want to conduct, which is to figure how far we have to drive payments down before the doctors finally say, no, we won't. We sort of know the answer on the other side of that, that using the MEI, adjusting for productivity, doesn't create a problem.

Now maybe we should be taking a look at the MEI. There are ways to think about this without saying, the right thing to do, let's try 3 percent next year and if the doctors still come we'll do 5 percent for 2008. And if they still come we'll push harder. That seems to me a sort of

loony path to even contemplate much less --

MR. HACKBARTH: That's a straw man sort of thing. Actually what these people are thinking about is not running that experiment on Medicare beneficiaries, but as opposed to 2.7, 1.5, which is what they've tended to do. That's the range they're talking about. Nobody's advocating, let's cut the rates by 5 percent and see what happens. That's a straw man.

MR. SMITH: But the argument, Glenn, suggests even that if the access data that we use is to be the barometer of adequacy, then you could equally well argue that Congress is overpaying the doctors. We've recommended too much. Congress hasn't followed our recommendations, but nonetheless, they've paid too much because the doctors keep coming.

I don't know how you untangle that. I understand that saying we just push them way down is a straw man. But I don't know analytically how you ask yourself, how you come up with a different answer than the question, then let's try to tweak it. Maybe we should try for a while pushing the productivity assumptions up a little bit.

But I don't think there's any dispositive answer

to the question in the way that you pose it other than running that experiment and seeing what it took.

DR. CROSSON: I think it's not surprising that there should be a different relationship between volume and payment for physician services because physicians are, in a semi-unique situation in terms of influence over demand or the volume of services, compared, for example, like hospitals and some other areas of payment.

It seems to me that the approach that MedPAC has used traditionally, which is similar to other Medicare services, of looking at the input costs, make sense. It particularly makes sense, or I guess I would say I would be quite averse to seeing physician payments cut by 4.3 percent or whatever is projected, particularly because, as we mentioned earlier, of the differential ability of certain physicians to actually deal with that cut by increasing volume of services in imaging procedures and the other kinds of reactionary sort of things that we've been seeing. That's not spread evenly across physicians and would probably differentially hurt some physicians more than others.

Having said that though, I think that going

forward the eventual a solution or stabilization of this process is going to depend on coming up with some mechanism within the payment process that does in fact deal with inappropriate increases in volume. That's the sticking point, because the SGR mechanism is a blunderbuss, and ineffective at that.

DR. WOLTER: On the issue of our recommendations versus what updates have been occurring, I think there's a terribly unique situation here in that the SGR and how it affects the current budget process is very different for this particular payment silo at this moment in time. So even a negative update puts on paper very, very large, billions of dollars of additional costs that somehow has to be made up, and we don't have that same kind of dynamic going on in the other silos.

So my preference would be for us, as best we can, to use the best information we can to recommend the right policy rather than compare what we recommend to this budgetary unique situation that's unfolding. At least that's how I personally would look at it.

A couple other comments I have. I don't think we have a good handle on whether or not Medicare reimbursement

for physicians is quite adequate. I think the access proxy is one thing. It tells us something, but I'm not sure it tells us enough. Marshfield Clinic and some others have recently done some interesting work on practice expense suggesting that that particular dataset underestimates a practice expense. Maybe that could be expanded and we could look at that.

My sense of physician access to capital is that it's minimal, if not close to zero. So if we were to put some information together about that I think we'd find a very different circumstance in the physician world in terms of capital access. So I worry about that, particularly with all the demands that are coming down the pike on physicians for pay for performance and implementation of technology and that sort of thing. So that's just really a caution there.

DR. STOWERS: I don't want to state the obvious, but in the presentation we talk about the difference in growth in different specialties. Yet when we get around to talking about the physician update we go back to a blanket number to do that. It just seems we suddenly get inconsistent in that. You wonder if there's not some way, if we're really going after volume, to adjust the update

according to the specific areas of physician services that are causing that volume.

I know that's been said before so I'm saying it more as a reminder. There are large parts of the industry, including primary care and others, that are very stable in their volume and yet are going to be having an increased cost of business coming on every year, where there's not a volume problem. So it has always bothered me that we start throwing a blanket decrease out there in areas where either the volume is stable or even dropping, or availability of care is dropping.

There should be somewhere in our discussion to get more specific that -- and you've said that many times before.

DR. NELSON: I think we need to bear in our mind the fact that -- the point wasn't made on the slides but it's in the text, that on average across the country Medicare rates are 80 percent below the prevailing private sector rates; payments. That in the short term we ought to stick with the policy that we've had in the past in recommending an update that would meet the input prices of an efficient provision of services, and replace the SGR with

an MEI that's based on that.

While we can't specify a number with the uncertainty about what this year update will be, or next year, nonetheless, we can and should continue to articulate that as an underlying premise for our recommendation.

But the third point is, in the longer term, the Commission should come to grips with the prospect of fundamental changes in the way physicians are paid, to take into account the need to more adequately pay for coordination of care, and management of care, and prevention, and incorporating higher payments for good quality care than for lousy quality care. Arnie introduced that subject in our previous discussion, but what I think we need to do is come to grips with that as a major effort on the part of the Commission rather than trying to tack that on to our current policies.

DR. MILSTEIN: I'd like to reinforce what Alan just said. In particular, Alan referenced something that we have not yet found a way of pursuing, although I think it is doable, and that is to begin to answer the question, what should the update be in reference to what our understanding of what efficient provision of physician services look like.

There are examples around the country of physicians, some within Jay's organization and many outside of Jay's organization, that have begun to ask the question, are there ways of substantially improving physician throughput, holding quality and practice pattern efficiency constant?

In our recommendations historically we have not yet incorporated the Congressional notion of what kind of an update is needed for the efficient practice of any provider, within any provider group. But I think there are some opportunities within the physician sector, and I don't think between now and next month it's not possible but I'd like to reinforce Alan's notion that if we're going to address this we also examine this question of what an efficient physician, specifically to this provider category, needs in order to deliver high quality services with an efficient practice pattern longitudinally.

MR. HACKBARTH: Anyone else?

Okay, let us now turn to the public comment period. I am greatly surprised to see Dr. Rich at the microphone.

MR. RICH: I promise I'll make my comments brief. I know a lot of you are trying to get to the Northeast where

there's a storm going.

First of all, I'd like to thank the staff and the commissioners for consideration of my comments last month. I'd like to separate my comments and address the issue of the crisis in primary care that was addressed by Dr. Milstein, Crosson and Ray. There is not a linear relation between valuation, income and manpower. As we found out, manpower is very, very complex when we look at the GMNAC reports.

To answer your question, Mr. Chairman, about the devaluation of EM, I had some research done by my staff who -- she was delayed by a storm in Chicago. But if you look at the 150 highest volume codes from 1992 to 1995 the relativity of EM is really maintained. There's only six codes of very low volume and low impact that exceeded the increase in work RVUs for EM. Again, if you go back to Bob Berenson's work at the Urban Institute, total RVU not from 2002 to 2004 but from 1992 to 2002 indeed has gone up.

So why hasn't the income, and why do we have this crisis in primary care? As. I believe it was Mr. Scanlon pointed out, we cannot increase the productivity and the throughput in a primary care physician's office. So despite

the increase in valuation, 36 percent work, if our work recommendations go through, 8 percent move to a single conversion factor, 20 percent practice expenses. We have not seen the increases in income because they are fixed, they are time-based codes with strict evaluation and management guidelines, and family doctors and osteopaths in general cannot increase their throughput.

I just finished consulting with Tom Bodenheimer who's a family practitioner at the University of California, San Francisco and he came to the same analysis that I have, that indeed the process with income is due to an decrease in -- the inability to increase productivity. I can do it as an ophthalmologist moving my cataracts from a slow outpatient department in a hospital to an ASC and double my productivity without increasing the rate per 100,000 beneficiaries. Ray cannot do that.

I'd like to briefly address the specific staff recommendations. The RUC recommendations for representation. Again, it is a Senate type thing. You're not allowed to debate your codes. It's a secret ballot. I'd point out that there's 26 rather than 23 voting members and certainly osteopaths are considered primary care.

To address Ms. Burke's comments about what percentage of EM is done by other specialties, and it's actually fairly substantial. OB/GYN is 50 percent, urology 34 percent. If you throw in the eye codes, I'm 42 percent. So there a lot of specialties that provide EM.

Having said that, both discussions with ACP and with the AMA, there is consideration to add new spots to the RUC and target them for pure cognitive services.

Recommendation two, an expert panel, great idea. Again, because frankly, doctors are not going to walk up to the RUC and say, I'm overvalued. I think it's a wonderful mechanism for the five-year review.

Automatic review, I agree with all the comments about change in volume and change in site of service.

Automatic reductions. As Dr. Reischauer pointed out, there is huge variability in new codes, and we will supply those to you. Some of them do have new technology, or where clinical staff time could be substituted. Currently, starting in 2005, the RUC flags these when they come through as new codes. They don't wait for a five-year review. They are brought back in a time basis, two to three years, to look to see if indeed technology has changed the

physician work.

Also, we look very carefully at practice expenses. We have a look back provision that CMS has adopted now and I think that's actually a huge area that's been overlooked. But we have a volume or a dollar amount of devices or cost of equipment that automatically triggers a review in, I think it's two to three years. I'm not sure.

Recommendation five, mandated periodic review. Good idea, but as some pointed out, huge resources are needed. We've already reviewed 85 percent of the codes, the codes that provide 85 percent of Medicare expenditures. The remaining ones are very, very low volume, 200 cases a year, 50 cases a year. I think there has to be some thought given into expanding that and looking at the work entailed.

Again, thank you for the time.

MR. REGAN: Mr. Chairman, my name is Jim Regan. I was here last month. This is my second visit in a row. It's not that far for me. Fortunately, I only have to come from Georgetown so even in the snow it's not too bad. I'm a practicing urologist at an academic medical center. I'm a member of the RUC. I've been a member of the PEAC almost from the beginning. I'm chairman of the American Urologic

Association's Health Policy Council.

In the two meetings that I've been here I've been struck just a little bit about the fact that primary care for some reason seems to be a sacred cow. Of course, I need primary care physicians and my patients need primary care physicians and I don't mean to denigrate them in any way. But I would like you also when you address manpower issues or you think about that, think also about, for instance, my specialty, urology.

My mother, my primary care colleagues all seem to say, oh, you're a urologist. But my response always is, yes, but sooner or later we're going to get you. And that's true with our aging Medicare population. We project maybe a shortage of as many as 2,000 urologists by the year 2020, so I just wanted to speak to that.

The second thing I wanted to mention is to address what Bill had said, that not only do primary care physicians do E&M services and submit bills for that, so it's wrong to think, as we all are guilty of, of saying, E&M equals primary care. That's not always the case. Nor is it the case to assume that cognitive physicians do not do procedures or do not bill for tests or imaging. That also

is happening as well.

The third thing and final thing is, along those same lines, I think it's wrong to carve out E&M for primary care and assume that their E&M is somehow more valuable than my E&M. As urologist I give longitudinal care also.

I would just like to thank you for your time.

MS. McILRATH: Sharon McIlrath with the AMA. I just wanted to make an observation about the findings that you had on the quality MACIEs and to just note that that causes a problem with the SGR, because as you found, more things were done in the physician side. Yes, that did you create savings over on the hospital side. But in the silo mentality that we have, physicians are going to be penalized for that.

I also wanted to point out that on the billing numbers, I don't know if this is actually reflected in there or not, but there were some changes. CMS was encouraging people to go to individual billing as opposed to billing through a clinic number. You may want to look at that and see if that has any effect.

Finally, I just wanted to say with regard to the Secretary and the suggestions that the AMA provided, we

provided them with a list of 45 things that was collected from the specialties on things that they thought were contributing to volume increase. CMS looked at four or five of those. They did not look at things such as the impact that practice parameters, quality measurement, was having on the volume of physician services.

So one of the things that in fact you have identified in this report they did not pay any attention to. So I do not think that their assessment -- not that the list was ever intended to say this is a complete explanation. But I do not think that their particular review was very comprehensive.

MR. HACKBARTH: Okay, thank you and we'll see you in January.

[Whereupon, at 11:49 a.m., the meeting was adjourned.]