MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, January 15, 2004
9:15 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Public comment

MS. SMITH: I'm Alyse Smith with the American Health Care Association representing skilled nursing facilities.

First of all, I just wanted to express my deepest appreciation for this work that is going to be done on the dual eligibles because, as we have said so very often, because of the great percentage of dual eligibles in nursing homes this truly affects and impacts our ability to provide care.

I just want to mention one thing, and we will supply the MedPAC staff with this information. All across the scene it is as if the left hand does not know what the right hand is doing when it comes to the particulars of some of these programs. For instance, MedPAC staff said that unpaid copayments are covered by Medicare as allowable bad debt.

What has happened at the end of last year is that the Centers for Medicare and Medicaid Services issued a proposed rule proposing a reduction in bad debt allowance of 10 percent in the first year, 10 percent in the second year, 30 percent in the third year, and hen forever after 30 percent to equalize it, so to speak, with the 30 percent on the hospital side that was put in place by statute.

There was no mention in the proposal rule of dual eligibles. The word Medicaid never surfaced. There was no mention of the percentage of dual eligibles in nursing homes, the percentage of Medicaid patients in nursing homes, and the potential percentage of very high bad debt attributed to unpaid copayments regarding Medicaid patients.

We supplied all of this information to CMS and to their credit, at least to this point, the final rule has been delayed and delayed because I think it is being further scrutinized. I simply raise this because all of these pieces are out there and few people have tried to put them all together in one place.

Thank you very much.

MR. CALMAN: I'm Ed Calman. In General Counsel to the National Association of Long-term Care Hospitals. I have one observation and two comments.

The observation is I really want to tell you what a fine job your staff is doing in their long-term care hospital study. I've been around for awhile. This study is being done with more than ample resources, appropriate resources, an open mind, and a sincere dedication to getting the right answers. I think you ought to be very proud of them and how they are proceeding.

My two comments are as follows: in the discussion of long-term care hospitals in the public materials there's the statement that long-term care hospitals provide post-acute care services to a number of stable medically complex patients. Patients who are admitted to long-term care hospitals are not necessarily stable. Long-term care hospitals have most of the resources of other hospitals. Patients in long-term care hospitals, they have codes. They have management of medically complex cases that are

unstable. The objective is that they become stable so that the wound and the weaning in the same patient can occur.

That's my only comment with respect to the findings that were made today.

I'm impressed and interested in the discussion of dually eligibles because long-term care hospitals have a stake with dually eligibles. I sit at my desk and I get phone calls from various states. The one that's the worst is Alabama, where there's only five Medicaid days allowed per year. So a dually eligible that's a long stay in a long-term care hospital, and we have them, ends up with zero Medicaid coverage, especially in the states of Alabama, Mississippi, and Texas. It's very unfortunate because the incentive is to drastically underserve these patients.

And I'm familiar with Alabama, all of these patients or most of them end up in one state hospital that's run by the University of Southern Alabama. And then they bounce from nursing homes to hospitals. If a study was done on their morbidity, I think they would be true victims of this Medicaid eligibility system.

When we had the Catastrophic Coverage Act of 1988, the one thing it did that was not controversial was do away with the Medicaid day limit. And it did not cost much. I remember I was looking at the CBO cost of that, it was scored separately. And that brought a uniform standard of care to all these patients across the nation for hospital care. And it was a real shame that it was repealed because that was a great leap backwards for these cases. And if a study was done, I would assume that morbidity went up because of that action by Congress.

At any rate, thank you very much for your inquiry into these areas.

MR. FENNIGER: Randy Fenniger, Federated Ambulatory Surgery Association. I have what I trust will be very brief comments on the recommendations that have been considered and voted on.

First, on payment advocacy, we've expressed this before and continue to be concerned that since there is no data, the Commission falls back on the use of proxies which we think are not an accurate reflection of whether reimbursement for a given set of procedures is adequate or not.

You're looking at an ASC system that has evolved into what it is in terms of Medicare, not what it might be. There are some 2300 covered procedures, many of which are not done with any great number in the ASC. I would wonder are those rates, in fact, adequate, inadequate, why are they not being done in the ambulatory surgery center when they are being done in the hospital outpatient department?

So I think that the lack of data is a handicap. We urge a great deal of caution in your evaluation of how well we are or are not doing based on the proxies that you've established to date.

I would only make an observation here, in dealing with urologists, who have started to move into the ambulatory surgery center arena in small numbers, not compared to ophthalmology or GI. The primary reason is not the rates. They all complain about the rates at the ASC level. It is the efficiency of the

model. They can do twice as much work in the ASC as they can in any hospital in America. And so it is a quality of life, it is an efficiency of practice that motivates them.

And I think as you consider adequacy of rates and some of the other issues that came up in discussion, you have to look at all of the motivations for the development of these centers.

Your second recommendation, which you voted on, I do not understand the discussion around capping the ASC rate at the HOPD rate whether or not it's determined the ASC cost is higher than the HOPD rate. if it is higher, pay it. If it's not, pay it at the rate at the cost that it exists. But to simply say this is the cap, you've got to live with it no matter what we learn, seems to me a rather arbitrary decision to make, inconsistent with the idea that was expressed in part of the discussion that what we want to do is try to figure out what the costs are and then make sure we pay our fair share of those costs.

So I would encourage you to move away from that kind of arbitrary cap idea and deal with the numbers as the numbers ultimately come out, if they ever do come out.

The collection of data to constantly or continually evaluate and update a new payment system, the existing payment system, any payment system, is theoretically a wonderful and necessary idea. In the ASC industry history works against us. Unfortunately, the Department has a very poor track record, as has been discussed here many times, in the collection of data about ASC costs and activities.

We're very concerned that if your recommendation goes forward and, in fact, gets incorporated in whatever new payment system comes out, that we will be again held hostage to the unwillingness and/or inability of the Department to collect this information.

I don't have an answer to that but I hope that you will consider this very carefully as you go forward because part of the reason that these issues have been brought to your attention has been problems with data collection and updating the system in the past. Please don't put is in that box again by another recommendation. We would welcome your advice to not only us but to the Department of how to get around this problem so we don't relive this particular situation.

Recommendation number three, the comment on the development essentially of a new coverage process for ASC procedures being done either simultaneously or after the completion of the payment system, I would argue strongly there is no reason the Department could not work on the development of new coverage standards. They have done some work going back to '98 which was published, never adopted.

I can certainly understand not introducing that until you've introduced a new payment system. That would be chaotic. But we think that it makes very little sense to introduce a payment system and not at the same time come in with new coverage rules. So we would ask that you consider that aspect of that timing so that both come out at the same time.

Again, being very concerned that if they issue the payment system, they haven't looked at the coverage rules, my

grandchildren will have grandchildren by the time we see new coverage rules, just based on history.

You dropped the issue of the physician office. We thank you for that. I would only note that the practice expense portion of the physician payment is calculated differently than all other costs in the HOPD or the ASC. You're going to have to grapple with that issue when you come back to it.

I would also note that anything a doctor does in his or her office they can do in the outpatient department of the hospital. There's no limitation. Why would you put an arbitrary limitation on their going to the ASC with they can go to the HOPD. I just don't understand that.

Deja vu all over again, self-referral. Just a few comments if I may, without trying to grind my teeth because I've been through this so many times.

When Stark was debated, the specific issue of the ASC ownership was debated. They were dropped from the legislative consideration, the reason being the ASC was seen as the extension of the practice. The physician refers and then goes to perform the service himself or herself, a vastly different scenario than referring to a laboratory radiology center in which you have ownership interest, benefit from the referral, but do no work yourself. I think that distinction holds. We would certainly argue that in a 30 year history of ASCs there's no evidence of overutilization.

I do know that when the Florida people, back in the early '80s, looked at these issues, they did examine ASCs in Florida, found no problem worthy of raising, although they did find problems in laboratory and radiology which ultimately became the basis of much of the legislative consideration.

Interestingly, the safe harbor for ASCs requires owners to do a certain amount of their practice in the ASC, thus forcing volume into the ASC if you were an investor. So one part of the law is saying you've got to do it there. And so when you think of self-referral issues, you have to keep that in mind.

I am struck by the issue of conflict of ownership of an ASC by a physician. I don't see that that is any different, if there is a conflict at all, than ownership of a physician by a hospital. If we can't own things, they shouldn't be able to own people because they own practices and employ physicians. And I think if there is a potential for conflict and abuse, it can exist in any of those settings. Frankly, I don't think it does exist, but I think the potential is there and they should be evaluated equally.

Finally, the movement from the hospital, which I know you will be talking about in other guises, I would give you one anecdotal situation. Why do procedures move out of hospitals and into other settings?

Empire Blue Cross-Blue Shield, some of you, perhaps Dr. Rowe is very familiar with them as an insurance company, sent a letter to gastroenterologists in their coverage area who practice at hospitals, mostly teaching hospitals in New York and Long Island, saying we're dropping you from our plan. Why? You do too many endoscopies in the hospital. So go do them somewhere else if you

want to stay in our plan. Do them in your office or do them in an ASC. A particular hammer on a teaching institution.

But here you had a private insurance company, the largest private carrier in the New York metro area, saying we want you out of the hospital. We won't pay you. We won't send you patients. We won't pay our enrollees if they see you.

So there are a lot of things going on to move things out of the hospital and into other settings other than perhaps income aspirations of some owners or investors. I'd simply ask you to keep that in mind and investigate that very carefully as you move into this, not only with the ASCs but the specialty hospitals. And I'll be back for that one, too.

Thank you.

MR. MAY: Don May from the American Hospital Association. I just want to make a couple brief comments.

I really appreciate all of the discussion that you had here today. The insights and perspectives that you all bring to the various subjects are very enlightening and helpful to us to hear all the different perspective.

Two things. One is on the dual eligible discussion. It becomes pretty obvious that our health care system, if you want to call it a system, is pretty broken. It's broken at how we provide care and how we pay for care. And it really raises some fundamental questions about how do we change how we do this versus tweaking it and all the little pieces that we do on an annual basis in all the different programs we have.

But I guess we do have to tweak. And so for the tweaks, let me just raise my second point on the outpatient outliers issue. We definitely agree that there's a problem in how outliers are currently paid in the outpatient system. And I think the real problem here is not that outliers aren't necessary in the outpatient PPS, but that the unit at which they're paid is too small, which frustrates us all when an x-ray seems to be the most reimbursed item in the outpatient PPS outlier system.

I would offer two thoughts there. One is we definitely need to increase the bundle and look at how we pay the outliers.

The second thing is I think it's based on the fundamental flaw of the outpatient system that it's underfunded. You've set an average payment for outpatient and an averaging system where the average payment is well below the average cost and it makes it very difficult for an averaging system to work when that average payment is set well below the average cost of care.

We were somewhat concerned today when we didn't see some of the other options that were discussed last month around raising a threshold, at looking at expanding a bundle. And I think that had some different analysis been done to show if you change how you pay outliers, it may have driven some results that may have been more in line with what I think people were frustrated that they didn't see, that outliers were going to the most expensive cases. Which is really what we care about, is covering the most costly cases, either the new procedures that are first moving out of the inpatient setting into the outpatient setting, or that happens to be the train wreck case that really does cost an exorbitant amount of resources.

We still believe that they are very important, especially since the outpatient system is still very volatile with changes in payments from year-to-year at the APC level, and in particular losing the transitional corridor payments that go away beginning this January. The extra protections that were in those payments are now gone for the hospitals who are doing some of the most costly procedures. And we really do believe that those are necessary.

Thanks again.

MR. HACKBARTH: Okay, we are adjourned. Thank you.

[Whereupon, at 12:07 p.m., the meeting was adjourned.]