MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 24, 2003
9:40 a.m.

COMMISSIONERS PRESENT:

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

AGENDA ITEM:

Public comment

MR. CLENDENAN: Good afternoon, Mr. Chairman, and members of the Commission. My name is Peter Clendenan. I am the Executive Vice President of the National Association for the Support of Long-Term Care. I'm here specifically to address recommendation one with respect to competitive bidding for durable medical equipment.

Our organization represents non-profit organizations and for-public organizations to supply ancillary services and products to long-term care and home health facilities.

Accordingly, our members provide durable medical equipment, disposable supplies, specialized therapies, physical, occupational, and speech therapy, as well as lab, x-ray, software, and other services.

We're actively engaged with both MedPAC and CMS in a series of cost containment procedures and we see competitive bidding as simply one more layer on a series of layers to cost contain. Specifically, we've worked with CMS on inherent reasonableness, as well as on consolidated billing.

Our point today to you would be competitive bidding is one more layer on a relatively confusing set of other cost containment procedures. I would urge you to reconsider the action you took with respect to recommendation one on competitive bidding. We would urge you to let the existing cost containment procedures work before you add another layer of complexity to Medicare reimbursement.

Thank you.

MR. FORD: Hello, my name is Tim Ford. I am from Elder Plan, one of the social HMOs based in Brooklyn, New York.

I just want to speak on behalf of the S/HMO model and the actions that you have taken today. I will be brief.

I just want to say that the S/HMOs, I believe, have earned the right to permanency. And I think CMS, through the risk-adjusted payment system, did lay out a framework to achieve this under a different payment model, which I think refutes a lot of what was -- or I won't say refute, but corrects a lot of the impression that was in your report to Congress which Senator Lott, on the issues that we were overpaid.

The second thing I want to say is that the proposal that I believe, if I understand it correctly, that you've recommended does not, in fact, give us the frailty adjuster through 2007, as was laid out by CMS, and actually reduces our current payment system over that seven year period.

If I understand that correctly, that will be very damaging to our members. What I think maybe you don't understand, you think of that as a 5.3 percent add-on that comes for all of your payment. But that payment is actually directed towards people that are determined to be nursing home certifiable.

In the case of Elder Plan, we have members that are nursing

home certifiable that, with that eligibility are recipients of expanded benefits. In our case, specifically up to $7,800 of community long-term care benefits.

Those benefits are very important for keeping them out of nursing homes. I can tell you that when the payment is taken away from us, we will have to seriously address whether we could continue to provide those benefits. It would be very difficult to do that. So a disproportionate share of our membership will receive the impact of that.

The second thing is, I'm not sure if the whole group actually understood the frailty adjuster and how that was developed. But just to do it in about a minute, the way the frailty adjuster was is they took population and ran it through the 66 condition model for the fee-for-service population base for that. They looked at what was unexplained, what cost was unexplained after running the 66 condition model, took that residual, and modeled how to correct, using ADLs to correct payment for the rest of that.

And that's something that wasn't done uniquely for the social HMOs but it was the approach they're taking for all the specialty plans.

And the determination of whether your population is frail and not frail comes form the Health of Seniors Survey, which is a survey of 1,000 of your members. And they return the surveys, that records their ADLs. And then, based upon your distribution within the 48 ADL groups they lay out, that becomes your ADL adjuster. So there is a rationale to that that I think is grounded in some solid work.

Lastly, on the issue of do the S/HMOs provide value benefits to their members. The reports to Congress could not find definitive evidence that they did, or certainly that was the comment of many.

However, I think it's also correct to say that they did not find evidence that they did not. In fact, both reports pointed out a number of things that they did well in terms of targeting resources to the frail, care management programs and initiatives, risk screening and decreased hospitalization of at-risk populations and others.

In context, there's really few evaluations in health care that are definitive and dramatic on their own in a single study. And that's why in health services research there usually are multiple studies conducted and results must be replicated.

Yet in the case of the S/HMOs, they really have not even been the recipient of even one well-designed evaluation over the 18 years that they've really been in existence. In fact, over those years, the notion of what they were intended to achieve has even changed. Originally designed to integrate long-term care services into the medical model in order to avoid nursing home placement, they were later evaluated based upon their ability to provide unique geriatric focused models of care.

The former, the ability of whether we are keeping people out of the nursing homes, has still never been studied. There's never been -- if you look in the reports to Congress, you'll see no comment on that.

And the latter, about the geriatric focus, really became the basis for the S/HMO II. And that study is still underway. The report to Congress was really based upon 22 months of study but that didn't necessarily mean 22 months of interventions that have been in place during that whole period. So that's really continuing.

So one thing we would say is that the S/HMOs would continue to contend that their true value cannot be evaluated until the targeted outcomes are more clearly stated, and better studies are designed and implemented and the plans are given ample time during that evaluation to demonstrate their impact.

My final remark is to say that I think it's in the best interest of CMS for its beneficiaries and for its planning and its programs to encourage innovation and not to discourage experimentation. I think what you proposed actually goes a step back away from that.

What I think we do need is better evaluations so that we can focus, not just passing judgment on the programs but what they do well and what they don't do well, so we can learn from those and integrate those into the models of care that we provide for our Medicare beneficiaries.

Thank you.

MS. FOSTER: Good afternoon, thank you for this time. I'm Nancy Foster with the American Hospital Association.

I wanted to express, on behalf of the 5,000 hospitals and health systems that we represent, our appreciation for your discussion this afternoon of the issue of quality and ways in which we can promote quality through better payment or better structures, as you have come to the language.

I wanted to make sure that you were aware of an initiative that we have launched in collaboration with the Federation of American Hospitals and the Association of American Medical Colleges and with significant and substantive support from CMS, the Agency for Health Care Research and Quality, the Joint Commission on Accreditation of Health Care Organizations, the National Quality Forum, the AARP, and the AFL-CIO. And hopefully I'm going to be adding to that list over time.

We have launched an initiative which we call Project Public Trust. The thrust of this initiative is to ask hospitals to voluntarily share significant information on quality with the public they serve. We'll begin small with 10 measures selected from the set of measures that are included in the seventh scope of work around heart attack, heart failure, and pneumonia, and expand on that by adding to it measures of patient experience of care, because getting that patient-centeredness we think will be extraordinary valuable. Over time we hope to expand this measure set to be much more robust.

But we struggle with some of the same issues that were reflected in the discussion you just had about quality. That is the fact that we don't currently pay for some of the most important issues in quality and we don't know how to measure some of those important coordination of care issues.

We'll continue to struggle with that as we try to find ways to make public information on hospital quality and those key

aspects of it. But we hope that we can coordinate our efforts with yours as we move forward.

Thank you for the time.

MR. HACKBARTH: We will adjourn and reconvene at 2:00.