MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, October 9, 2003
10:11 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
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
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

MR. HACKBARTH: We will have a very brief public comment period before breaking for lunch, if in fact there are public comments.

MR. ROYWELL: My name Bob Roywell. I'm with the Visiting Nurse Associations of America, and as someone recently introduced me, I'm a recovering CMS employee. In any event, it would be hard to add anything to the discussion we had today but I'd like to just make--if I had a slide up there with five points on it that I would like to emphasize, the first is that although I think it was said in a different way, is that disease doesn't develop into chronicity in a physician's office or in a hospital. It develops in the home and community, and I think that's where the solution to this problem lies.

Secondly, we really need to have a model that integrates physician and perhaps nurse practitioners into the homes in a home care plan if we're going to solve this problem, particularly the people that we deal with. We're not privileged to be funded very often for prevention. We receive the lion's share of our funding for people who, as someone put it, have crashed and burned, often with multiple chronic conditions. If we're successful in rehabilitating them to the point in 30, 60 or 90 days where they're somewhat ambulatory and somewhat more able, then Medicare funding ends and they're left at the tender mercies of what comes next.

So I think my next slide would be continuity. It is a tragedy to see people leave home care only to return six months or six weeks later because there has not been continuity, whether that continuity is through private insurance or through a Medicaid system which doesn't integrate terribly well in long term care when people leave Medicare onto Medicaid, not to mention the delicate dance between Medicare and Medicaid cost shifting, which would be amusing if it didn't hurt so many people and didn't exhaust limited resources.

Fourth, I think we have to realize we have to integrate some of the disease management principles into what we have talked about in terms of aggressive or intensive care management. I think one without the other is not going to be successful.

Lastly, I think to be successful this has to reach the fee-for-service population. Unless the system changes more dramatically than it's changed in the last 20 years, for the foreseeable future we're going to be dealing with primarily Medicare in a fee-for-service system. So we have to be able to reach that population and I think the people that reach that population have to be incentivized to enter into these programs, and they also have to know that they deal with people with whom they have some community connection and some confidence.

Thank you.

MR. HACKBARTH: Okay, we will reconvene at 1:00.

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