MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, October 10, 2003
9:02 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
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

MS. FISHER: Karen Fisher of Association for American Medical Colleges.

I have four hopefully brief points. First, we appreciate the discussion on the outpatient outlier payments. In our comment letter submitted on the most recent proposed rule, we also pointed out the fact that with the current threshold the amount of absolute dollar costs that very high cost items would have to achieve to even qualify for an outlier payment is vastly different than a high-cost item. So we feel similarly to where the Commission is on that.

We also believe, though, that I don't believe was discuss this morning, that if you believe in the merits of an outlier payment policy then not only should you look at the threshold, but we believe the Commission should give some thought and discussion to the payment percentage for those services that meet the threshold. It's currently at 45 percent of cost above a threshold and CMS is proposing to move that to 50 percent. The inpatient payment percentage is 80 percent.

We believe if these are legitimate high-cost, extraordinarily high-cost, services that merit an outlier payments and the hospital has to eat the cost up to the threshold, that to be consistent with the inpatient system -- and it's just a matter of fairness -- that that payment percentage should be increased.

On two related but separate items, we're concerned about the expiration of the transitional corridor payments that occur at the end of 2003. Our look at the data, those transitional corridor payments were meant to be a three-year set of cushion payments so that no hospital would fare extraordinarily poorly when the PPS was implemented. Our analysis of the data and hearing from some of our members, they are relying a fair amount on those corridor payments and are concerned about what will happen when those corridor payments end at the end of 2003.

I think it would be useful for the Commission to examine those payments for multiple purposes. I think it was a useful mechanism at the implementation of a new payment system and then to see what goes forward.

Finally, in terms of the suggestion about encouraging innovation in the outpatient system, I'd like to raise an issue to you that has perplexed us over the past several years. That is the outpatient payment system contains an inpatient only list. And that is a list of services that CMS has determined will not be paid for by Medicare if performed in an outpatient setting. They are deemed to be provided for only on the inpatient setting.

We have had problems with this list from the get-go. First of all, we believe that there are other checks and balances for determining when care can appropriately be moved from the inpatient to the outpatient setting. So we believe the role of CMS even in this setting is not necessary.

That being said, the criteria for which CMS determines when a service moves from the inpatient setting to the outpatient setting is perplexing. Because this area issue arose to me at the meaning I don't have the exact detail, but as I recall the criteria was a significant number of hospitals had to be performing the service on an outpatient basis in order for it to be moved from an inpatient to an outpatient basis.

That doesn't make sense when you're looking at it from a major teaching hospital perspective where these services will first be performed. They have to start somewhere, the outpatient setting, before they can be defused to other places. So for basing your criteria to move it off of the list that you have to have a significant number of hospitals providing it, doesn't make sense to us and we think could quelch innovation in that area.

So we think that is a straightforward type of a potential recommendation for the Commission that we'd like you to consider. Thank you.

MS. SMITH: My name is Elise Smith, and I'm with the American Health Care Association. I have just three points.

First, a comment on the issue of the possibility that skilled nursing facilities are actually increasing. Our association has somewhat different data. We have OSCAR data that seems to suggest that, in fact, the certified facilities are decreasing. We have a number of about 17, 014 from June '99, going down to about 16,347 in June of 2003. We will provide our data and hopefully discuss this issue with the MedPAC staff.

But I bring it up here because I just want to remind you of the phenomenon out there that if you think you are seeing an increase in certified units or beds, it may be in great part due to the increase in dual certification. There are states out there that are on an increasing basis requiring Medicaid nursing homes to provide Medicare and vice versa. So we believe that this phenomenon, if indeed it exists as an increase, may be in part due to that. We just bring your attention to that and we're going to try and find out more information about that.

My second point is the issue of capital access. It doesn't really matter who might, in numbers, dominate this industry. I simply wish to bring your attention to the fact that the capital access problem is widespread throughout the entire sector, affecting multis, affecting SNF freestanding facilities, both for-profit and nonprofit.

Just one sentence out of the CMS market report, the outlook for the smaller and not-for-profit facilities may be bleaker compared to the larger for-profit facilities. That starts on page 21. And if you want some pretty bleak details and a bleak picture, you will find it -- unfortunately, you will find it there.

Last, but not least, the issue of total margins. Ms. Raphael's comments on trends in Medicaid rates regarding nursing homes is crucial. It is an increasing problem, as you all know. You only have to look at the latest Kaiser report to see some pretty bleak trends. Not a day goes by on Capitol Hill that there isn't a hearing involving the increased Medicare crisis.

What is the bottom line with all of this? Well, as you

probably would see it coming, what I want to emphasize is that the focus should be on the health of the entire sector, and that requires looking at total margins. I believe Jack Ashby yesterday said that you have looked at total margins in the hospital arena for context. At a minimum, we would appreciate the same contextual approach. But really, we believe that the time has come to try somehow to move towards an analysis of total financial health not only of the SNF sector but all of the provider sectors.

Thank you for your attention.

MR. FENIGER: Randy Feniger with the Federated Ambulatory Surgery Association. We're the largest trade group of ambulatory surgery centers. And just a few comments and observations on the work plan that was discussed earlier.

First, as you look at reasons for growth in the industry, I think it's very important to look at the change in medical technology and anesthesia techniques over a period of time which has certainly contributed to the ability to move things from more complex inpatient settings to settings of outpatient ambulatory surgery-type arrangements.

Look at the efficiency of the ASC versus the hospital for the same service. If the hospital takes an hour to turn around the endoscopy suite for the next patient, and you can turn the same room around in your ASC in 10 minutes, the efficiency will drive the doctor and the patients into that environment. So I think that's a very important issue to consider as you do.

Also, from the point of view of the physicians, their control over the quality of the service that is being delivered. They have control over staff, other kinds of things that they think are important, that they may not have in a hospital setting. So I think those are issues that should be incorporated as you go forward and look at that.

The regulatory environment at the state level is extremely important in the distribution of ASCs, and it's critical that you look at that very carefully. And also, measure -- since Medicare is a static rate across the country, distribution is going to be driven in large part by the private insurance climate in given parts of the country. Those that favor ASCs, you're going to find more use of them. Those that tend not to, you will probably find a different distribution. So we would encourage you to incorporate some of that analysis within your work.

As you look at access to capital as a measure, and I know we went around on this issue last year as a proxy for determining why the industry was growing, there really are two different capital markets you have to look at. One is publicly traded companies like AmSurg and some of the others who are essentially going to Wall Street to get their money. But a group of doctors who finances something locally, through the local bank, that's a different capital market. And I think you really need to look at both.

I think that gets to the point was made earlier about not considering ASCs as a lump, as one thing. They are different. They're different in their structure. They're different in their specialization. All of these are factors that I think should be

incorporated.

We are more than happy to work with your staff to offer up what information we have that may assist in that differentiation, so you get a clearer picture of what's going on in the various sectors within the ASC industry.

Once again, we come back to gee, we have no data. We had none last year. We don't have any this year. And that complicates your analysis. The analysis is also complicated because you have an archaic payment system with a very limited number of buckets for payment compared to hospital outpatient department, inpatient DRGs, or any of the others.

This has prompted the industry, and Mark and Ariel were at this meeting, to talk to Congress and the conferees and now make a proposal to actually identify a way to collect data. We don't think the survey is probably ever going to get done. We have to find some alternatives.

And then, using that data and subsequent analysis of that data, to have CMS make recommendations to Congress for changes both in the payment structure for ASCs as well as the coverage rules.

So this is a proposal that we, as an industry have put forward to Congress. Time will tell if they accept it, but we think that there is general agreement across the industry that what we have today is not working as well as it should. It needs to be changed. The fact that it hasn't been changed over these many years, well there's nobody to blame for that. It just hasn't changed.

But I wanted you to know that we have made this recommendation as an industry and we look forward to working with your staff again and with the members of the Commission. We invite all of you to visit your local ASC, and not as a patient, but as a visitor on a guided tour. We will arrange that for everybody, even in those most rural parts of America. I'll find one.

DR. WAKEFIELD: [Off microphone.] Or build one.

MR. FENIGER: You know I can find anything in a rural area, if I have to.

And we appreciate your consideration of these comments and look forward to working with you and the staff. Thank you.

MS. ST. PIERRE: Mary St. Pierre with the National Association for Home Care.

I just wanted to let you know that we would be very, very happy and pleased to work with MedPAC on analyzing the data and looking at those areas within zip codes where there may not be the appropriate access to service that the beneficiaries need. We have close contact with the state associations and they are always ready and willing to help with projects like that.

I also want to let you know that NAHC has analyzed over 6,000 home health agency cost reports and we have that information that we're very happy to share with you. This is a project that we will continue to engage in for an indefinite period of time.

I think that the information that we have obtained in analyzing these cost reports shows a potential growing problem as

far as margins for home health agencies that there is a large number of home health agencies that are in the red and an increasing number in the next year that will be in the red with the reduction in payment and we're particularly concerned about the loss of the rural add-on.

I also wanted to mention that as the OASIS queen at the National Association for Home Care, I receive questions every day about how do I answer this particular OASIS item. And so I would be very pleased to volunteer my services to help in identifying which of the outcome measures may be more appropriate, where you're getting better input from the providers, more accurate input from the providers, that give a better management to the outcome and the care that they're given.

Thank you.

MR. HACKBARTH: Okay. Thank you very much and we meet next in December.

[Whereupon, at 11:59 a.m., the meeting was adjourned.]