MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 4, 2003
10:13 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
NANCY-ANN DePARLE
DAVID F. DURENBERGER
RALPH W. MULLER
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

MR. HACKBARTH: We'll have a brief public comment period.

MS. FISHER: Karen Fisher with the Association of American Medical Colleges. I wanted to jump in first because my comment relates to your most recent topic on the outliers. I'm going to continue the analogy of not doing math in public, I'm nervous because I've been thinking and I'm going to think in public here and that may not be a wise thing.

The issue of the outlier payments, first of all I would say teaching hospitals are in favor of accurate costs because teaching hospitals, we believe, tend to treat the complicated cases. When you look at accurate costs -- and that's the intention of the outlier payments. When you have a set pool of money, if there are people who don't have accurate costs, it takes money from those who have accurate costs for high-cost cases.

There's the issue of what do you do with the cost to charge ratios, et cetera. The inpatient outlier final rule last year -- and I've been informed by my colleagues that this whole issue of using more recently settled and submitted cost reports to try to eliminate the lag period with cost to charge ratios we think is going to eliminate a lot of the gaming that was associated with the outlier rule.

The issue of going back for egregious people and trying to settle I also hear from my colleagues is limited to the inpatient only, and I think it's a reasonable thought for this Commission to think about on the outpatient side.

I would say that we also have to remember that CMS has shown that for high-cost services the markup tends to be less than for overall services. So when you look at that cost to charge ratio and you look at the high-cost, complicated services, this issue gets a little bit more complicated because the markup is not as high for those services.

I'm a little quizzical about the impact on the beneficiaries under the three options. It seems to my under option one, to eliminate it, we're not sure what the impact is on the beneficiaries because we're not sure what the impact of eliminating the outlier policy would be on the low-volume, high-cost services because they don't show up in the outlier tables contributing to the large amounts of the outlier payments.

On the second two options we say it better protects beneficiaries if we limit it to higher-cost services or to a certain set of services. I would say that if you just do that

it would have no impact on beneficiaries because that's what's occurring now. It's occurring now for those high-cost services as well as the low-cost services. What would better protect beneficiaries though is that if you limited the number of services that would be eligible for an outlier payment but then increase the outlier payment threshold, which is currently at 45 percent, we believe that if you're truly dealing with accurate costs and you're limiting the outlier payment policy to the high-cost services, why are you only paying for 45 percent of the costs above the threshold, which is already twice what the cost amount is? So it's quizzical why you wouldn't increase that threshold.

We would suggest if you go down a path of limiting the number of services and the types of services that would be eligible for an outlier payment that you give serious consideration to increasing the outlier payment percentage that those services would be eligible for.

We're also concerned because if you again look at the data and believe that major teaching hospitals tend to provide a number of these services and then you look at the transitional corridor payments which are going to be eliminated for major teaching hospitals at the end of this year, and if you believe some of the reason for the transitional corridor payments is because they're providing high-cost services, the need for an outlier payment policy in the future is more important than ever.

Thank you.

MR. ARMSTRONG: I'm Doug Armstrong. I'm with AAHP-HIAA. We are the nation's trade association representing about 1,300 of the nation's health insurers, including those that provide coverage to more than 200 million Americans. I'd like to say that I'm having a little bit of difficulty in reconciling the inequitable way that the Commission is recommending incentives for quality. This morning the Commission recommended withholding 2 percent of all plan payments and then rewarding only those certain plans that meet or exceed certain quality thresholds. While this afternoon the same commission recommended withholding just 0.4 percent of inpatient payments and then returning them to all facilities that only have to meet reporting requirements with no accountability whatsoever for meeting or exceeding any sort of threshold. This seems to be very inequitable, and it is.

What it actually does is it completely discriminates against one portion of the health care delivery system and that's the insurers. I know that we would greatly appreciate you re-examining what you're using as carrots and sticks as providing incentives for quality throughout the health-care

industry.

MR. MAY: Don May with the American Hospital Association. I want to thank you for a very rich and lively discussion today that kept the room pretty full even if we are at the end of our useful life for the day. A couple things. One on outpatient, to start there and the outlier provision.

I think we feel, as Karen mentioned, that there does need to be an outlier provision. Outpatient services are changing. Many more things can be done on an outpatient basis. We don't know what the cost of those are going to be and it probably makes sense to have an outlier policy.

That being said, having it pay at a very discrete level, at a very small bundle probably doesn't make as much sense as expanding -- either by setting a higher threshold or by looking at all the services provided on one day. I don't know if that's at a claim level, because I know the data is very complicated, but in a visit, when you come to a hospital, maybe look at what the costs are for that day, accumulating the cost for a visit, regardless of how many APCs are there, see if that was a high-cost patient because of all the multiple things that had to be done and then compare what the payments were to try to get at a better, reasonable outlier system in the outpatient program.

Like Karen, I think that a lot of the changes that CMS has made around cost to charge ratios and using more current data to get there has gone a long way and will go a long way in addressing some of the data concerns that show in this old data, but this old data, as she mentioned, doesn't reflect some of the changes in policy.

I would say, however, that we would very much urge you not to recommend cost settlement of outpatient claims. That would require regenerating every single claim using new cost to charge ratios, and there are many, many more outpatient claims than inpatient claims. It would be a very, very burdensome approach at looking at outliers and is something that we would be very concerned about that excess burden put on the system.

On to payment adequacy and the update recommendation. When I look at the data and I look at Medicare margin dropping every year since 1997 I look at the trend in the overall Medicare margin dropping and the projection for it to drop in 2004 again. What I see is declining payment adequacy and really we don't have payment adequacy in Medicare. That's why Congress passed a prescription drug bill with many provisions in it to help rural providers, other providers, other hospitals, because the payment adequacy isn't there. You have more than half the hospitals in the country losing money providing care to Medicare patients. That is inadequate.

When you look at that aggregate and you say it's at 4

percent or 3 percent or now it's at 2.4 percent and things are still adequate, that does not take into account the variability and it doesn't allow you to move toward where we need to go in improving the technologies in our hospitals, the information systems, building average age of plant, which is at its oldest in years. So I really would urge you to rethink what we're determining is adequate because I don't see adequacy in those numbers.

As far as the whole cost allocation issue, I think we heard today arguments for the cost allocation is still an issue, arguments by the same staff that cost allocation may not be an issue. I really think we should just start showing the margins. The home health margins in hospitals are deplorable. That's why we have hospitals getting out of that service. They can't afford to provide the service. Regardless of how you look at cost allocation, hospitals and organizations are making decisions based on whether they can afford to stay in that line of business, whether they can afford to do that for their communities, and clearly they can't. So cost allocation aside, the home health margins by hospital-based providers are falling and dropping and that's why hospitals aren't able to provide those services.

If you look at some of the blanket terms on capital, access to capital is still a struggle for many hospitals. More bond downgrades than upgrades, and with a downgrade comes, even if you have investment grade, more expensive cost of capital. We just showed the cost of capital was going up. That is a reflection that hospitals have reached a point where they have to invest in their infrastructure. They're doing it at a higher rate. So I really would challenge the Commission and the staff to look at some of the access to capital arguments because we really do see with half the hospitals not having positive Medicare margins, a third of the hospitals losing money overall, there really is an access to capital problem. With all of the demands on hospitals to improve infrastructure, to improve information systems, to address some of the quality and patient safety issues, these are very expensive and those cost increases are very real.

On the science and technological advancements, and this is particularly for outpatient but I thing it applies to inpatient as well. While there are some mechanisms to pay for certain clinical devices or new drugs, remember that science and technological advancement and the science and technological advancement in health care that's going to be the breakthrough that will all of a sudden allow us to lower length of stay again is not necessarily just a drug, but it could be information systems, it could be other things in the hospital that aren't

necessarily tied to a service but may be tied to many services. I'd encourage the staff when they talk about science and technological advancement to really talk about all of science and technology, not just the clinical components.

On productivity, we continue to be very concerned about the use of the productivity adjustment, the 0.9 percent reduction of the general economy's multifactor productivity growth. To think that one industry can continue to have productivity gains year after year after year is probably asking a lot. That general economy is based on the cumulation of all the industries going up and down on an annual basis. But to expect that the health care field and hospitals in general should be able to hit that every single year I think is somewhat ambitious.

I also believe, and we've been doing some work on this issue, that when you look at the industry, health care and hospitals are very labor intensive. There's a lot of evidence out there that suggests that the more labor intensive an organization is, the much more difficult it is to have the same types of productivity gains for lower labor related industries. I think, based on some of our preliminary work, the general economy may be overstating by as much as twice the rate of productivity that can be gained in an industry that heavily relies on labor. You saw those labor costs driving up cost of hospitals; the 6.6 percent increase, the cost that Jack suggests might be happening in 2002 primarily being driven by labor.

I would argue that it's very difficult to suggest that there is going to be a productivity adjustment of 1 percent when you've got such a labor-driven group, yet we're going to take away billions of dollars with that adjustment assuming that we can just take out 1 percent out of -- in productivity on an annual basis when it is something that's focused on labor.

But those are just some of the comments. We will, obviously, be sharing more information on this productivity analysis. We'd just encourage you to rethink about this issue of payment adequacy and whether with a productivity of minus 1 percent really make sense given the cost trends that we're seeing.

Thank you.

MR. HACKBARTH: Thank you.