MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 5, 2003
9:05 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.
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Public comment

MS. SMITH: Since I seem to be the only one between you and you and making your planes, I will be as succinct as possible.

My name is Alise Smith, I'm with the American Health Care Association and our major concern, of course, is long-term care and a focus on skilled nursing facilities.

I have just a few points and I will run through them as rapidly as possible.

First, regarding the forecast error correction. That is what it was, a forecast error correction. And it was CMS saying fundamentally that that money had already been spent by the SNF sector and that the market basket three years in a row did not pick it up because we had estimated market baskets and not actual market baskets and thus we got forecast error correction.

Secondly, the issue of the dual eligibles. Well, I don't like doing public math anymore than anyone else, and I hate pulling percentages right off the top of my head. I wish I had a cheat sheet here, but I do believe that a credible figure is 60 percent of the residents of nursing homes are dual eligibles. And I will check on that and provide Susanne with the figure that we have. It is an extremely high figure.

Which leads me to a fundamental point. There are 6 million, now I just saw a Kaiser figure of 7 million dual eligibles in the United States. And their care impacts obviously heavily in costs on the long-term care sector.

There's one interesting point here, regarding Ms. Raphael's comments yesterday on the application problem or the distribution problem in the home health sector. Remember that now there are enormous efforts going out there in the states to shift to home and community-based care. Beneficiaries should be served in the most appropriate site. If it's a nursing home, so be it. If it is home and community-based care, then that care should be efficient, but it should be well funded, monitored, and the labor market and the people who are trained to care for dual eligibles should be there.

On the skilled nursing side, we have somewhat of an analogous problem with our population being 60 percent dual eligible. Well, we've been here before with our argument about total margins and we understand your argument about not carrying Medicaid on the back of Medicare, but this cannot be ignored.

It's a puzzling fact why the mixture of Medicaid and Medicare has only really historically been broached in the hospital sector with the concept of disproportionate share. Now

I don't follow disproportionate share issues and maybe they are somewhat controversial now, but disproportionate share is an add-on, if I'm not wrong, to Medicare. Not to Medicaid, but to account for that high acuity and comorbidities of the Medicare/Medicaid patient. We do not have that, to my knowledge, in home health. We do not have that in the skilled nursing facilities sector.

On the issue of taking 6.7 percent and redistricting it down or elsewhere to clinical categories, I think there are so many complex issues that have to be addressed to support such a recommendation. In discussions with Corbin Liu at the Urban Institute, I am impressed with the fact that the issue of trying to determine what the real SNF cost drivers are is an exceedingly complex one. By January 2005, Corbin Liu and his colleagues will have given their best shot at a comprehensive analysis of what drives skilled nursing facility costs and how best then to treat those in a prospective payment system.

I will check with someone like Corbin, but I doubt that there's any analysis out there, any data out there, any way possible that CMS, even if they were given authority by Congress, could pick and choose what funds should come out of which categories and to which categories those funds should migrate.

In relation to that, I had thought, given prior sessions, that there was going to be a deeper analysis of hospital costs, including cost allocation across hospitals and hospital systems, and the impacts of that allocation on -- well, call them subsidies or entities that are hospital-based -- that's the correct term, -- such as SNFs. I think we should have some further analysis on why those costs are high, if they are indeed higher, and some balance to the argument we hear often that it is all due to acuity, some kind of analysis to balance the acuity argument, which we think needs to happen.

Last but not least, and I think I'm picking up on the comment of another commissioner, the issue of stability in these sectors is an extremely important one. Capital access, for example, has been horrendous in the SNF sector. We think it may be improving now, but that is difficult to determine.

These sectors, these health care sectors, are very large ships that do not turn very easily on a dime. When you look at issues like beneficiary access or capital access, I am wondering if there could be some deeper explanation of how good is good, how bad is bad, and how can you start to tell when good can turn to bad?

What I'm trying to say is that capital access, which he hoped would now be improving, if we lose an update factor, could start back down in the wrong direction. There has to be some

horizon, some sense of what might be up there on the horizon, that the decisions that you're making today will impact.

I just think it would be helpful if a somewhat deeper explanation could be provided in the final report on these issues of if you do, how you try to determine the cumulative effect of a decision made today and how fast it will affect a sector and what the results might be.

At any rate, thank you very much for listening.

MR. FENIGER: Randy Feniger with the Federated Ambulatory Surgery Association. I, too, will try to respect your flight times, although I've been in Washington long enough to know that nothing I will ever say will keep either a commissioner or a congressman from missing a plane. So if you need to leave, you will of course probably get up and leave.

I want to really address three items quickly. The ASC industry and its relationship to Medicare is poised to change. The Congressional action in the Medicare bill that was just enacted will clearly do that, assuming the Department does its own job, and I assume they will, by 2008 we will have a very different system.

I was pleased to see that the Commission and its staff have begun to incorporate some of that thinking in their own recommendations that they are presenting to you, because I think that really is where your emphasis ought to be, where are we going, not where have we been. And I think that's where the Commission can make the most valuable contribution over the next months and years is in looking at that change, answering some of the questions that were raised today about relationships between HOPD, ASC costs, services, et cetera.

I hope we can get away from the notion or the discussion of the fact that there are a few procedures that paid in the ASC more than they are paid in the hospital outpatient department. We, I think, spend too much time talking about 327 procedures out of the total 2,300 or so that are covered under Medicare. Perhaps what we ought to concentrate on is all of the other procedures that are poorly paid in the ASC compared to the hospital, and the impact that has on patient copays and their out-of-pocket costs because the services are generally not available in the ASC. It might be interesting to look at that.

Our industry is frozen until 2009. Hospital outpatient got 4.5 percent this year. There are not frozen. I think any differences in payment, even without changing the payment systems, will vanish while we stay at zero and they keep growing at 4.5 percent or some comparable clip.

The migration of services out of the hospital is inevitable. It's happening more rapidly now, it is happening to ASCs, it is moving to physician offices, it is moving to

hospitals that specialize in certain kinds of care. I think what the Commission should do in looking at the ASC, and really looking at many other kinds of providers, but particularly ASCs, is think about what is the appropriate place to provide the care? Where can we provide it safely, most effectively, and most cost efficiently, whatever that setting is.

I heard some comments that seemed to me to be sort of the hospital as we have known it since the 14th century is entitled to be preserved, ergo we can't possibly change the payment system for ASCs or some other because we'll do some societal harm. Rather than think that way, I think the Commission could profit by looking at what are those services that the community hospital provides best, compared to other settings, and how can we reimburse them, whether it is through private plans or Medicare, your particular bailiwick, in ways that maintain their viability, rather than saying we're not going to innovate, we're not going to allow the transfer or migration of services from one setting to another because we have to protect something.

I don't think there is a provider entitlement to Medicare. I think that goes to the patient. I think Medicare ought to look to the best possible use of its dollars.

ASCs work for patients and they work for physicians and the staff. The growth that you have seen described to you, I think is a very positive thing. I don't think it's going to stop. It has obviously curtailed to some extent by state regulatory environments, insurance environments in different parts of the country. But this is a model that works very well and I think it is one that the government, and through your advice the Congress, should encourage through appropriate and proper reimbursement, rather than discourage.

We look forward to working with the staff and with the Commissioners as we move forward to a new payment system, and we hope that most of your energy will be devoted to that particular effort because we think that your experience can bring great value to that discussion and debate.

Thank you.

MR. HACKBARTH: Okay, we're finished. Thank you very much and we'll see you in January.