MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 12, 2001
10:27 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
AUTRY O.V. DeBUSK
GLENN M. HACKBARTH
FLOYD D. LOOP, M.D.
ALAN R. NELSON, M.D.
JANET G. NEWPORT
CAROL RAPHAEL
ROBERT D. REISCHAUER, Ph.D.
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

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MS. FENNEL: Thank you. I'm Karen Fennel. I'm senior policy analyst with American College of Nurse Midwives. I think earlier Craig pointed out to you under Part B billing of the Medicare program, which is where nurse midwives bill when supervising students, that we can't get reimbursed. You might wonder why we're so concerned about Medicare when you only look at about 300,000, a little over 300,000 deliveries a year in the Medicare program.

However, what's happening to us is that Medicaid and private insurers are looking to Medicare and they have decided not to reimburse our faculty. We are having clinical site after clinical site close down. I have a major program that this was one of the major reasons they will close this year was the lack of being able to collect monies when supervising students.

So essentially what's happening is our nurse midwifery faculty, who are not employed, by the way -- the majority of our faculty are not employed by the hospitals. They are in their own practices. They can't collect and there's a free service given.

We would hope that as you look at education and cost of training, not just of the staff nurse, that you would also look at the advanced practice nurse as well, and possibly give some guidance to HCFA and to Congress on this issue. We'd be glad to provide you more information.

Thank you.

DR. WILENSKY: Thank you.

MR. GRAEFE: Thank you, Gail. Fred Graefe with Baker & Hostetler on behalf of the American Health Science Education Consortium, which is the 700 or so hospitals that participate in the nursing and allied health pass-through program. I think it was a fair resolution in adopting the two recommendations that you did.

A couple of comments. The Congress in its wisdom in about '88 or '89 capped the number of hospital-operated programs, so that number has remained steady. That's why there has been "no growth" in the program in additional hospitals building and operating and owning hospital-operated colleges of nursing and allied health. So that explains why, in one sense why the growth in other academic

areas has occurred. It's also occurred -- obviously, you're the health policy experts -- because payers have demanded additional non-physician health professionals; to wit, APNs at Oxford in New York City and other places.

Finally, Congress is actually considering this issue -- not as we speak since they're on recess -- but they will be addressing this issue, I'm assured, in the Medicare reform this year on expanding the nursing and allied health program to include non-hospital settings, if you will, in the Medicare program and in some appropriated accounts.

Finally, I think making a suggestion about moving Medicare dollars, transferring to appropriated dollars would be viewed I think by people on the Hill as sort of kicking the can down the road. It really doesn't answer the question of what to do about increasing the supply of nurses. I think that Congress is looking at this year. I gave Craig a copy of all the bills that have been introduced to date. There are two identical bills introduced in the House and the Senate that deal with the Medicare issue specifically.

So thank you for your time and attention to this issue.

MS. HELLER: Hi, I'm Karen Heller with the Greater New York Hospital Association. I wanted to talk a moment about the issue of the labor share, of the standardized amount. I have a very special interest in this because any redistribution, about 25 percent of the money would come from my members in New York City. I modeled the 63 percent number yesterday because that's simply the number I had heard. It was about a $2 billion redistribution over five years, about $450 to $500 million in a single year. It's real money to us, much more than the aggregate, bottom line margin of our hospitals today.

At any rate, I'm very, very gratified and reassured by the conversation that you had. I feel that your interest is not in arbitrary reduction of the labor share, but is sincere interest in looking at what parts of costs are driven by local versus national markets.

Now my comment. Just as you were saying that the assumption about all of the labor components of the

marketbasket are local, likewise there's an assumption that all of the non-labor components are national. So as we take our sincere look at what the components mean in terms of local and national, I just want to make sure that you will ask HCFA to look at both the labor components and the non-labor components, because it's quite possible that we want a cross-sectional input price adjustment on the non-labor component as well as the labor component.

My intuition is that it would be a wash in terms of the part that's adjusted today, because my familiarity with empirical analyses have shown that if you look at the wage index as an explanatory variable, the coefficient is around 70 percent.

So I just appreciate the ability to say that and thank you very much.

MS. LOVE: Hi, Marian Love from the American Organization of Nurse Executives. I just want to make a couple brief comments on your conversation about nursing education today.

First and foremost, we would love to see the

Bureau of Health Professions division of nursing play a more significant role in the preparation of nurses. Unfortunately, our history from the nursing community with regard to securing and expanding our appropriations has not inspired great confidence in this approach as a sole source of funding for nursing education.

To that end, I think also I want to address the question of, is there a potential for inaction as a result of taking some more time to examine the issue of, are there enhanced patient care costs and value in those facilities where Medicare is providing pass-through dollars. I think the answer to that is, given what we are seeing in the media, in the private market, and in the congressional action that was mentioned by one of the previous commenters, I think the response to that is, no. I think there's a lot of efforts ongoing and that will continue, and we support those initiatives.

Lastly with regard to removing the current funding from those programs that are ongoing, one of the issues that we're dealing with right now is trying to maintain the

ground that we have as far as preparing a workforce, let alone putting ourselves in a position where we might see the closure of these programs as a result of loss of funding and then having a year or two delay in reconstituting those programs elsewhere. At this point, with this nursing shortage we can't afford to lose that ground in the interim.

So we do appreciate support for the ongoing role of Medicare in those programs right now and hope, as we explore other ways to provide a sufficient workforce, that we can address those issues down the road.

Thank you.

MR. CALLEN: Mark Callen, Health Care Association of New York State. First of all, I would like to thank Karen for pointing out the dramatic impact that redistribution can make on a technical improvement to policy. I'd like to put a picture around that.

In New York in 1999, two-thirds of our hospitals had operating losses; about twice the number that losses in '97. With respect to Medicare, almost 40 percent of New York's hospitals had negative margins in 1999, compared to

1 26 percent in 1997.

2 In the midst of this, we are experiencing a

3 significant shortage of nurses, aides, therapists,

4 pharmacists, and other health care workers. The average age

5 of an R.N. in New York State is 48. The average retirement

6 age is 52. Only 10 percent of working RNs in New York are

7 under the age of 30. Enrollment in nursing programs

8 declined by 19 percent over the past five years.

9 Certainly we need a long term solution, but there

10 is the short term impact of increased labor costs that our

11 hospitals are about to experience. We can't afford any

12 reductions in Medicare reimbursement as a result of

13 technical improvements that redistribute money. We would

14 really appreciate it if MedPAC staff would, as part of any

15 presentation, show the movement of money on some of these

16 policy issue.

17 Finally, I think you can understand in the

18 financial state that we're in, we do support the AHA's

19 agenda for getting money to address the workforce shortage

20 problem.

Thank you.

MS. COYLE: Carmela Coyle, the American Hospital Association. Like to thank the Commission, as always, for their thoughtful discussion today. Four points.

First of all, purpose. At least as I sat back and listened today, I remain a bit confused around the objective of this very important report that's going to the Congress on rural issues. I think one thing that was clarified is the purpose of the report was not to increase the margins of rural hospitals. Yet the analysis that you looked at and every option that was evaluated was evaluated based on whether or not it increased margins to rural hospitals.

It was also discussed that the purpose was to provide access to quality care in rural areas, and was also suggested, I think by the chairman, that it's about improving Medicare payments. But I'm not yet clear on what improving Medicare payments means. Does that mean to make payments more accurate, to make them more equitable, to limit anomalies, to make services more accessible?

To that point, would urge the commissioners to

review one of the recommendations you approved today on the issue of base payment rates where the recommendation reads, "conclude no change needed, reflecting belief that our recommendations will produce equitable payments." Everything I've heard today suggests that you really weren't trying to achieve equity and equitable payments. You may want to review that language.

Would also, to that point, suggest that this recommendation was written before you decided what you were going to approve. So you may want to consider redrafting that recommendation.

DR. WILENSKY: Excuse me, Carmela, that is not a recommendation and should not be characterized as such.

MS. COYLE: I'm sorry, I thought you approved recommendation number one.

DR. WILENSKY: It's not a recommendation. It indicates options. It is consistent with where we believe we are, which is that we have made a series of recommendations that attempt to refine payments under Medicare in appropriate ways.

We have looked to see how they would affect rural hospital and urban hospital margins because, as I thought was rather well indicated in the early discussion that we had with Julian's chapter and we had in the preceding Commission meeting, that what we are attempting to do is to, in our choices of just having money available to particular sectors like rural or urban or inner-city, is try to refine and improve our Medicare payments, and in doing so may relieve some of the pressures that were indicated.

The sense of where we ended up is that we are comfortable making specific recommendations and we're not comfortable in making a recommendation with regard to changing or equalizing base payments. So by implication, we believe that the appropriate steps to take now are to do these specific targeted changes and to not make further gross changes.

So it is consistent that that is the sense of the Commission. It was not a specific recommendation per se, nor was it voted on.

MS. COYLE: Thank you. That's a helpful

clarification.

To my second point, which is on the topic of information. As always, staff has done a significant amount of good work. But raise the question whether commissioners have all of the information, or at least some of the information that might be both helpful, important, and desirable.

You have talked a lot today about the dollar impacts. Other people have mentioned them. Just a couple of questions. On the DSH cap recommendation that you voted, had a dollar figure of $180 million. Does the Commission know whether that's a one-year impact, a five-year impact? On the low volume adjustment, the $22 million, is it a one-year impact, a five-year impact? And did you know that at the time that you were voting? Are these things new money? Are they budget neutral?

Just not clear. I hope it's clear to you, but from our perspective in the audience it wasn't clear. May be helpful to have that kind of information as you're making some very important decisions.

Third point is one of practicality. On the issue of the labor shares. Other people have commented. I'd like to comment from a different perspective. That is, having the Secretary study that may make some sense.

But if you think about what the Secretary would have to do to collect that data, presumably to actually inform this commission and policymakers, you would presumably want hospitals to collect information on every legal contract, computer contract, labor-related contract that they may have. To then report whether that contract is locally engaged or nationally engaged. To understand what the wage rates then are to really be able to get a sense of this issue.

So while the Secretary may study it, I think it's going to be very difficult for them to actually achieve that. And I think the burden of actually trying to do that well would be significant, even for you and your organizations around this table, to be able to quantify that.

To my last point and that is one of process. The

nature of my comments are somewhat limited and very different. I have said this for the record before, but would entreat, Madam Chair, would ask that this commission please consider allowing those of us who sit here, who are either greatly affected by the important decisions of this commission or people we represent are greatly affected by decisions of this commission, to comment as part of this public, open process before you take your votes as opposed to at the end of the day. I think the nature of our comments would be quite different if we were allowed to do that. So would just ask your consideration in that matter.

Thank you.

DR. WILENSKY: Let me make sure -- I hope that this is not new information for the commissioners, that the numbers we heard were one-year numbers unless otherwise said, and that we have indicated when they are budget neutral, and when they are not budget neutral that is suggesting additional monies. The largest non-budget neutral recommendation I'm aware of was basically an extension or a partial reiteration of a previous

recommendation with regard to DSH money that had quite extensive discussion about the fact that we were making a recommendation regarding new monies.

We are usually quite careful about making recommendations that involve new spending, indicate that, and indicate something about the implications of our recommendations. I regard the fact that we did not have more extensive discussion on that particular piece of recommendation is that it was a partial reiteration of our previous recommendation with regard to DSH, partially because part of it was already picked up in BIPA and partially because we did not feel it appropriate to make the full extensive recommendation at that time.

But I certainly assumed that the commissioners were aware that we were talking about one-year money, and additional money unless budget neutrality was specified.

I would be glad to take up with commissioners at our retreat this question of whether we have public comment before we have recommendations. But these are all recommendations that have been on the table since our March

meeting so I don't think there was anything that was new fundamentally in substance; obviously, wording changes.

MS. TAYLOR: My name is Pat Taylor. I'm an independent consultant and I specialize in rural health policy issues. I want to thank the Commission, and particularly the staff, for the wonderful amount of new analyses and information that we are going to have about the rural health care system and Medicare as a result of this report. It's just wonderful to be getting it.

But I do want to just comment very briefly on the limitations of the Medicare current beneficiary survey, using it for understanding what's going on with rural beneficiaries. That survey uses a highly clustered sampling frame, so there are 27 states in which there are fewer than 10 members of the sample, and that includes eight states which has no non-metropolitan members at all. So I think it's inappropriate to break it down by all these urban influence codes, as I think you have a chapter that's going to do that.

Then the second point is, in this sample in 1992--

DR. NEWHOUSE: Did I understand you to say there were some states that had fewer than 10 people in the MCBS?

MS. TAYLOR: Twenty-seven states.

DR. NEWHOUSE: That includes zero people presumably.

MS. TAYLOR: Yes.

DR. NEWHOUSE: I didn't understand how you could have clustered sample --

MS. TAYLOR: There are eight states that have no non-metropolitan members.

The other thing is, in the most remote urban influence codes, I estimate there are about 500,000 beneficiaries that live in this most remote code areas, and there are only 25 in the 1992 sample, which I think has not been changed much, the sampling design. There were actually 23 sample members from that category. That's just such a total under-representation, I think you can say nothing based on that survey about those people.

MR. FAY: Hello, my name is Tony Fay. I'm with Providence Health Care. We operate 55 mainly rural

hospitals throughout 17 states. I'm very interested in the work of the Commission. This is my first meeting.

The point I'd like to make is that BIPA went a long way in terms of providing DSH funding to rural hospitals that was not previously available, and we think the Commission's recommendation goes a step further. But I can say as the operator or working with a company who operates 55 rural hospitals that that is probably the biggest payment disparity between urban and rural hospitals. We would hope that eventually the formula, the same rate would be paid to rural hospitals that is paid to urban hospitals in terms of Medicare DSH.

DR. WILENSKY: Commissioners, you have a half-hour before we reconvene for dinner, and then we will reconvene tomorrow at 9:00.

[Whereupon, at 6:32 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Friday, April 13, 2001.]