MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, April 26, 2002
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Public comment

MR. HACKBARTH: So we're now to the public comment period. Any public comments?

MR. KALMAN: My name is Ed Kalman. I'm counsel to the National Association of Long-term Hospitals. We have the same concerns that were addressed by Dr. Kaplan to you earlier.

There was one matter which I briefly would like to discuss a little bit more, and that's the matter of crossover cases, and how they're affected by the proposed payment system.

CMS has clarified to us recently, about 15 minutes ago at this meeting, that in their policies they count crossover cases as discharges, even though they do not leave the hospitals. 9.6 percent of all discharges in long-term hospitals in the year 2000 were crossover cases. 25.5 percent of all days, that's combined Part A days and crossover days, 25 of them were crossover cases.

Of the 39 hospitals that are disqualified from certification by the proposed changed definition, that is using Medicare only days, 39 of them are disqualified because the crossover cases are counted as discharges, even though they do not leave the hospital.

The incentive of that policy is do not admit crossover cases.

The very short stay policy has an overall cost-to-payment ratio of 58 percent. For crossover cases, it is 27 percent. For crossover cases who die, it is 22 percent. That is another incentive not to admit crossover cases.

There is no disproportionate share in the proposed rule so there is no ability under the payment system to show the financial requirements related to these cases. And since payment for the financial requirements for the medically indigent is not in Medicare cost reports, there's nothing in the system.

I would say worse than all I have said is there is a federal statute that allows states to pay Medicaid providers Medicare rates. I'm fearful that states will look to the very low payment of very short stay policy to pay these providers for crossover cases. Because Medicaid cases in long-term hospitals are usually all crossover cases.

Finally, Medigap policy is, under a PPS system, is that Medigap insurers pay what and when Medicare would pay if they were going to make another payment, usually an outlier payment. In this case where I think 48 percent of the cases are paid on the per diem and the per diem is deep discounted for crossover cases, I am fearful that Medigap will pay much less than cost. Which means that the payment system as a whole, Medicare and Medicaid and Medigap, will not be budget neutral.

I think that these are serious considerations and I certainly hope that the Commission will consider them in making comments to CMS.

Finally, with regard to the wage index, I would request that some consideration be given to a rural adjustment if there's going to be a wage adjustment. In rehab PPS there's a rule adjustment of 19 percent. There were very long-term hospitals in

rural areas. They perform a unique function. There is at least one or two cases I know where there are rehab units in competitive hospitals in those areas, when the absence of a rule adjustment the long-term hospitals will be in a disadvantaged position, in terms of competing for labor.

Thank you very much.

MR. HACKBARTH: Okay, thank you very much. We're adjourned.