MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, September 11, 2003
10:20 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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AUTRY O.V. "PETE" DeBUSK
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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: **PAGE**

DR. SEAGRAVE: I will be very quick. I'm just going to touch on some highlights of what we're going to do in the skilled nursing facility area this year and then I'm going to present a few preliminary results just to give you a flavor of the types of analysis that are progressing as we speak.

So just quickly -- I won't say much at all about this slide, but this just gives you an overview of -- I was only going to say one thing. All right, never mind.

[Laughter.]

DR. SEAGRAVE: The payment adequacy I won't say much about except I wanted to highlight a couple of points that we're going to be stressing this year. The first three bullets on this slide -- we're going to be looking at all six of these issues but the first three bullets we're really going to highlight, especially the quality issue which was alluded to in a previous discussion, so I won't go into depth about it. But we are going to be looking at quality of care by reviewing the literature, by looking at staffing levels, by looking at MDS data, and by looking at preventable readmissions to the acute care hospital. So we really are going to spend a fair amount of time looking at quality of care in SNFs this year.

We also are doing some extra work looking at the relationship of payments to cost, or sometimes we call that margins. The reason I bring that up is because we are going to -- again this year we're going to try to make our margins as accurate as possible in reflecting the higher costs of SNF Medicare patients versus non-Medicare patients. We're actually working fairly hard on that.

Finally, on the access to care issues, since there were two payment add-ons that expired October 1st of 2002 we want to spend a fair bit of time concentrating on what experience beneficiaries have had accessing skilled nursing facility care since those add-ons expired.

The two special projects that we're going to be devoting a great deal of time to this year involve looking at hospital-based SNFs because a number of questions came up in our payment adequacy analysis last year regarding the role of hospital-based SNFs in the system. Then also we're going to be spending a fair amount of time looking at the RUG-III patient classification system for SNFs and how to improve that system.

So I'll start with our first project, which is looking -- with respect to hospital-based SNFs we'll be taking a two-pronged

approach. We'll be looking at their role in providing care in which we'll look at the types of patients who go to hospital-based versus free-standing SNFs. Once we've identified the types of patients, then we can control for the type of patients going to the hospital-based SNFs when we look at their outcomes of care and their cost to the Medicare program to try to identify the role that they're serving.

Next, we want to look at the effects of the closures. As I had discussed last year, we had a significant number of hospital-based SNFs close since 1998 effectively, and we wanted to look at, first of all, what are the characteristics of the facilities that closed? Were they located in certain areas or what was going on?

Also, what services may hospitals have replaced the hospital-based SNFs with. For example, we heard some anecdotes about the beds being used for other types of services.

And then finally, what effects have these closures had on access to and outcomes of care in the areas they served?

So that gives you an overview on our hospital-based SNF analysis. I just want to briefly tell you about our SNF patient classification system analysis. This will mainly involve reviewing the literature and interviewing researchers who have identified problems with the system and propose potential solutions. So we want to just review the whole range of potential solutions.

We also want to analyze patient populations and financial performance in individual facilities basically to get a handle on how well the system is targeting the payments to particular patients and particular providers.

And finally, we wanted to do a comprehensive review of the additional variables that might be useful in improving the patient classification system.

On to sort of the preliminary data that is coming out of our ongoing research on hospital-based SNFs. The left column labeled freestanding SNFs is simply for comparison purposes so that you can get an idea of the magnitude of hospital-based SNFs relative to all SNFs.

They are a relatively small portion of all SNFs, but of those hospital-based facilities that we identified as being active in 1997, a full 31 percent of them have closed since 1997 or terminated their participation with Medicare. So we wanted to try to look at, as I said, the characteristics of these hospital-based SNFs that have closed.

As you can see, those that were active in 1997 were predominantly urban nonprofit facilities. Whereas, of those that have terminated since 1997, they are disproportionately represented by for-profit urban facilities, which we thought was interesting. So this gives you some idea of who these facilities are.

And finally, I wanted to present some information. We also looked at the hospital-based SNFs' reported per diem costs in 1998. These are what they reported on their annual cost report forms. We found that of those that have closed since 1997, their costs were approximately 43 percent higher than the ones that

have remained open. So this was an interesting finding, as well.

And I'll be coming back to you throughout the year with more findings on our hospital-based research.

With that, I'll turn it over to our next, Sharon Cheng.

MS. CHENG: Moving on to our work plan for home health, here are some background numbers that we've updated for you this year. I'd give you context, but I'm trying to move. Please ask me questions if you would like some background on that.

Our core policy question for March is, of course, are Medicare payments adequate? This year we will apply 100 percent of fiscal year 2001 cost reports to our margin estimate. We've also begun to receive our sample for fiscal year 2002 cost reports, so we're going to be substantially better off this year than we were last year, in terms of the sample for cost reports for our margins.

We will also have a new view of access to home health this year. We're going to use CMS's new database on service area. We are going to be able to construct a map of the service areas, self-identified by home health agencies. We'll also be able to overlay a map of the Medicare population to get a sense of the population in and outside of service areas.

Among the distributional issues, we will continue to examine urban and rural differences, and we'll also start to look at the need for refinements to the PPS. One refinement we'll consider is a change in the outlier policy for the home health PPS.

To enhance our understanding of quality, we actually have two questions. To answer the first question for March, we will assess the quality of home health before and after the implementation of PPS. Our work will lead to a single national quality score based on the clinical and functional improvement and stabilization of beneficiaries under the care of home health agencies.

For June, for the second question, we'll use the new Home Care Compare database and will begin research on the relationship of cost and quality for the home health setting.

Finally, to enhance our understanding of the recent decline in use and it's implications for access, we will add an investigation of the data from the national home and hospice care survey. Nancy Ray is here to discuss with you the initial results of this research.

MS. RAY: So we pull data from the 1996, 1998 and 2000 survey. This is a survey done by the National Center for Health Statistics, part of the CDC.

We selected all patients, current and discharged, with Medicare as their primary payer for home health care and excluded anybody residing at any kind of hospital or inpatient health facility.

You have a table in your mailing materials that shows some preliminary results. Some of these results confirm what we found in our episode analysis that we publish in June of 2003. Increasing proportion of patients 85 and older, there no changes in the proportional of female patients. There were some new variables that we looked at using the survey, and that was one of the reasons why looked at data from this survey. More patients

with a primary caregiver. We looked at the ADLs. Fewer patients had no ADLs in 2000, even though more than half reported no ADLs in 2000. But there was a decline between 1996 and 2000.

Other findings that we found, increased use of physical therapy services, a slight decline in skilled nursing services, decline in use of home health aides between 1996 and 2000, as well as an increase in the proportion of patients with arthritis as an admitting diagnosis.

Next steps. There's additional data in the database that we will be bringing to you at the December and January meetings. We can look at episode length for those folks who were discharged. And we'd like to compare home health care use of Medicare patients with and without Medicaid.

DR. KAPLAN: I'm going to go through the next steps on the long-term care hospital study very quickly. You've seen most of this data before. You've got it in your handouts. They are still growing like mushrooms, popping up all over. That led directly to our policy questions for this study, which are also in your handout.

The primary objective, and I want to emphasize this, because the primary objective of this study really is to come up with criteria that Medicare should use to define long-term care hospitals and to define patients that are appropriate for them. I want to emphasize that.

We're taking several approaches to this. We have several quantitative analyses. We're going to slice and dice and look at the long-term care hospitals more closely to see if they're all alike or whether there are differences by their age, by their ownership status, et cetera, or whether they're hospitals within hospitals or freestanding.

We're also going to be doing multivariate analyses and looking at patients that have a high propensity to use long-term care hospitals, then see where those types of patients are treated in areas where there are no long-term care hospitals, and can then hopefully compare outcomes for those who use long-term care hospitals and clinically similar non-users.

We're going to have two qualitative analyses. One is structured interviews with physicians and others in areas with and without long-term care hospitals. Then we're doing site visits to long-term care hospitals.

Then the final step will be to develop policy recommendations.

This year will be our first opportunity to look at payment adequacy for inpatient rehabilitation facilities, which CMS calls IRFs. The PPS for these facilities started in January 2002. We are hopeful that we will be able to do this work but we are not certain because it will depend on how much cost report data is available for 2002 for these facilities.

Assuming that we can do the payment adequacy assessment, we'll use the regular payment adequacy framework. We haven't talked about rehab in a while, so I just want to quickly tell you they specialize in providing intensive rehab services. Their primary mission is to assist individuals in regaining maximum functional independence and to be eligible for inpatient

rehabilitation care patients have to be capable of sustaining three hours of therapy a day and benefitting from the care.

This is background on them. You'll be seeing these numbers again and again this fall. And the most frequent diagnoses we'll also talk about more in the fall. These steps I think you all know.

Let me just say that if we do get to a recommendation, we will, of course, look at cost differences.

Now onto hospice.

MS. THOMAS: We're going to look at the hospice benefit, use and payment issues this year. We didn't look at hospice last year, but we have looked at this benefit in the past.

The earlier analyses focused on end of life care and access to the benefit. In fact, the Commission has made recommendations that the Secretary evaluate the payment rate.

What's new this year is we have a couple of years of cost report data and we can begin to look at some of the payment issues.

I'm going to give a really quick overview of the benefit and eligibility for the hospice benefit. There's more detail on this in your mailing materials. I'll go over trends really quickly and talk about the proposed work plan.

The hospices must cover a broad array of palliative care including prescription drugs and counseling, which are not otherwise covered under Medicare. They are paid per day depending on the setting and the intensity of care. Most services are provided in the home, which includes nursing homes, although some inpatient care is also furnished.

Medicare has four rates. The rate for routine home care, which is the most common service, is $118 a day. And the highest rate, which is almost $700, is for continuous home care.

To qualify for hospice, beneficiaries must choose the benefit and they waive all rights for curative care for illness related to the terminal condition. Medicare continues to cover illnesses and injuries unrelated to the terminal condition.

Beneficiaries may opt out at any time and may change hospices. They must be certified by physicians as terminally ill with less than six months to live if the disease follows its normal course.

Beneficiaries in M+C plans can also choose hospice. They can stay enrolled in the plan or not. If they stay in the plan, they continue to pay premiums to the plan and receive any additional benefits the play may offers, but generally receive all of their Medicare services through the fee-for-service program.

There were around 2,200 hospices in fiscal year 2001. As I said earlier, the hospice benefit is generally provided in the home. But like other providers, for example home health agencies, hospices may be freestanding or based in other providers. A few are in SNFs, some are in hospitals, and others are in home health agencies. The benefit is the same regardless of where the hospice is based.

The share of hospices that is freestanding has grown 10 percentage points from 50 percent to around 60 percent over the

last 10 years.

Medicare hospice spending has grown rapidly over the past 10 years from less than $500 million in 1991 to $3.6 billion in 2001. Between the last two years on this chart alone, spending grew 25 percent. CBO projects double-digit growth through 2005, leveling off at 7 or 8 percent thereafter.

One reason for this growth is rapid growth in the number of beneficiaries using the benefit. It's grown more than five times over this 10 year period from $108 million to $580 million in 2001.

But recent spending growth has been even faster than the number of beneficiaries using the benefit in large part because there's been an uptick in length of stay in hospice.

There was some concern of the pattern of decreasing length of stay over the 1990s, but it seems that there's been a change. I don't know about underlying patterns within the length of stay. There's been some concern over short lengths of stay in the past, so that's one thing we'll look at.

That brings me to the work plan. I'll be working with Cristina Boccuti on this. We'd like to use the newly available cost report data to look at differences in cost by type of provider, length of stay, census, and by types of cost. That is if the data allow.

We'd like to update data on the length of stay to 2002 and see what the change in the distribution of stay has been between short and long stays. Depending on data available, we can also look at the use of the hospice benefit by M+C enrollees which over the past has been much higher.

We want to look at changes in the composition of the industry over time. And as we look at populations with high loss for disease management, as Joan and Nancy explained, we will consider hospice and how that array of benefits is provided for folks who are at the end of their life.

Finally, we'll report on the status of measuring quality of care in the setting.

MS. RAY: Everybody recalls that we created a post-acute care episode database. We published our first analysis in the June 2000 report. So the next step for this is to update the information in the database. We're going to include 2002 claims for the 5 percent file. That means we'll have data from 1996 to 2002. We're also going to include MDS and OASIS information into the database.

So I'm here to get your direction as to where you would like to take the analysis for the June 2004 report. As a first step, we do plan on updating some of the use and spending data tables that we put in the June 2004 report, but we'd like to take on additional work. And we can use the database to answer an number of questions.

We can look at outcomes of beneficiaries, pre/post-PPS. We can look at changes in Medicare spending for both post-acute as well as non-post-acute care before and after the implementation of the prospective payment systems.

And two other issues that we could use the database for, we can update MedPAC's analysis of factors influencing choice of

post-acute care setting. This was Chris Hogan, a couple of years ago, used data from the Medicare Current Beneficiaries Survey 1993 to 1997. He pulled it. He looked at factors influencing post-acute care.

In particular, he found factors such as hospitals having a SNF unit, high supply of nursing facility beds, as important factors influencing whether or not a person uses SNF versus home health care.

The last analysis that would look at is changes in patterns of care over time between 1996 and 2002, look at how patterns of care changed, the number of post-acute care providers. Beneficiaries are seeing the patterns for where they're going and so forth.

We would like to hear from you any other possible direction you'd like to take the database.

MR. FEEZOR: Sally, I had the opportunity a week or so ago to be in the audience for a chap who was peddling long-term care hospitals to other hospital administrators. And I just have to say that I was a little uncomfortable that there was a disproportionate amount of conversation on what it could do to the relative profitability by sending them your tired and your poor, as well as improving your hospital's mortality and some of its other ratings.

So I wonder, when you and Nick go on your road show, you may want to talk to one of the other, in addition to the referring physicians, maybe some of the hospital administrators or CFOs that refer an awful lot of business to them and sort of get an attitude, or at least some idea in terms of how they're being viewed.

DR. KAPLAN: The structured interviews that we're doing -- well actually, a contractor is doing with them for us, NORC and Georgetown are doing them for us, they actually are doing that. They have all of the hospitals that are referring to these hospitals in these matched market areas. They're looking at that.

MR. FEEZOR: I felt like I was in the old insurance market where you stratified your bad risk into a subsidiary and kept your good risk in a different company, so it was a little uncomfortable.

DR. NEWHOUSE: Two comments. One is I think more the March report and one is more the June report.

On the SNF analysis, but more generally on our update framework, there's really something of a framing issue, I think. Here it's what's the right baseline?

The data that we presenting or showing on exit were post-'97, disproportionately for-profit hospital SNF. There was a huge entry before '97. My guess is of the same entities. So that maybe we've come back to where we were in the earlier '90s.

But I think at a minimum, we should show that. It more generally raises the question that if we're going to use entry and exit as an indicator of payment adequacy, we have at least an implicit judgment about what kind of capacity we want. And we haven't, I think, often made that explicit.

On the June report, this is something quite different but it

goes both to the point of quality of care and accountability. And I don't think we've talked very much about the use of IT in the post-acute setting. That would both be capability and connectivity to the hospital and to the doctor. And particularly in the context of home care, electronic charting, which is to say I think goes to both quality and accountability.

I don't have any great ideas about what the work plan there should look like, if any, but I think at a minimum it ought to be on our radar screen. I have the sense that it's fairly minimal now, but we could say something perhaps about to what degree it's used and what degree we think it could contribute.

DR. KAPLAN: Let me just briefly say we have had some conversations with some of the industries about IT and we will be bringing that to you when we move through our payment update.

DR. ROWE: A couple comments about hospice. While the expenses are impressive and the rate of rise is impressive, it would be interesting to see an analysis of the savings, if any, because the patients have to forego curative treatment. And presumably while they're enrolled in hospice, they're getting admitted to the hospital much less frequently and not developing those costs.

So it's really not fair to evaluate the hospice program by just looking at these expenses without looking at some of the trade-offs. I don't know if that's done or not or it's available, Sarah.

MS. THOMAS: There have been a couple of studies that have actually looked at that, and actually found not great savings, in fact, a slight cost. Although the original evaluation of the hospice benefit found some savings, that was before this rapid rise in the use of the service.

I think the tricky thing is that those quick cross-sectional comparisons of costs really didn't control for a lot of matching of patients on their characteristics. And as time and data allow, we'd like to take a look at it in a more sophisticated way.

DR. ROWE: A couple of other comments. With respect to the length of stay, you've commented on this but it's just worth emphasizing, that we have to have a different mindset. When it comes to hospice, long length of stay is good. Shortly length of stay is bad. It's important to understand that the whole idea here is planning, getting people into the program early to prevent the hospitalizations that don't yield any benefit, to control their pain early on, to start to counsel them, to give bereavement counseling to the families, et cetera, et cetera. You can't do that in two weeks as effectively as you can do it in two months.

So long is good, short is bad. Since that's the opposite of the way we think about it in hospitals, et cetera, et cetera, in terms of length of stay.

Third is I think years ago there were very significant racial and ethnic disparities in utilization of the Medicare hospice benefit. African-Americans particularly didn't seem to have full access to the benefit, as I recall. I have a sense that that has gotten better but it would be interesting to

refresh those data.

MS. THOMAS: There was a recent article in the Journal of the American Geriatric Society on just this subject. And I plan on pulling a lot of that information together.

DR. ROWE: That's great. If you could send me that, I should have that but I'm a little behind on some of my journals. Now the Wall Street Journal, but some of the others.

[Laughter.]

DR. ROWE: And then the last thing is I think that there is some ambiguity about what whether or not hospice, as Medicare defines it with this long list of benefits that you listed, is the same as palliative care. I think we should try to clarify that because I think that there's hospice just the place. Then there's hospice the benefit, which includes hospice the place and a lot of other stuff. Then there's palliative care as it would be envisioned by JoAnn Lynn or Diane Meyer or the Robert Wood Johnson Foundation's Last Acts Initiative, which is a more comprehensive program.

I think we should be clear about how the Medicare benefit, at least, compares to hospice, just hospice the place, or palliative care in terms of comprehensive services.

Thank you.

MS. RAPHAEL: In regard to the nursing homes, I think the first study on trying to figure out a classification system that works is a far more important study, to my mind, than the study on what's happening with the hospital SNFS. Because we have spoken on numberable occasions about the inadequacy of the current classification system and the issue about refinement versus reinvention. So I consider that a particularly important study where I think we can make a contribution that's significant.

In terms of looking at hospital-based SNFs, I think we have to look overall at what's happening in occupancy rates in nursing homes. Because in order to see whether there are access problems we need to understand that, because there are issues here of substitutability with assisted living and your IRFs and home health care, et cetera.

And I think it is instructive that the states, who have tried to change their policies and shift Medicaid dollars to home care, have had a very hard time doing it. So that about 73 percent of Medicaid spending on long-term care still goes to nursing homes despite all their efforts to try to move the system toward home and community-based care.

I don't know if this as at all possible and maybe this is something far in the distance, but I would be very interested in seeing whether it's possible to take a case like a stroke patient or a hip fracture patient and see what happens if that patient happens to land in a nursing homes or in home health care or in an IRF or in a long-term care hospital.

This is only my hypothesis. This is not at all proven but I believe there are patients who could land in any of those four places due to things that are not necessarily attached to their clinical characteristics or their care needs.

It would be interesting if down the road we could really

compare the costs and the outcomes if it is at all possible to find a similar population. I know we have issues around people going into more than one post-acute care setting. I believe there were 18 percent who went to more than one. I don't know if I have those numbers right. But anyway, that is something I'm particularly interested in taking a look at.

Another area that I would like know more about from your database is out-of-pocket spending. The last time I looked at it, and I don't know if my numbers are current, about one-third of long-term care spending in the nation was out-of-pocket. And it was quite high. I don't know if that's at all true today, but I think it's worth taking a look at what the out-of-pocket spending is in the long-term care area.

I was going to make Jack's point on palliative care because there is a movement now toward palliative care. I, myself, am not always sure exactly what that label means, but there are now more palliative care units in hospitals, there's more palliative care partnerships between hospitals and I know home care and hospice agencies.

So I'd like to see if we can try to capture some of what is happening here and is it at all significant for the Medicare program?

Lastly, while we say that a number of, for example, home health care is not capital intensive and it truly, in general, compared to nursing homes and long-term care hospitals, it is not.

I have seen much more of a movement toward using technology. It's far more widespread than I would have expected it to be, given that most home care agencies, in fact, are quite small.

So I think we should take a look at the systems, whether it's electronic charting or what's happening in terms of connectivity between physicians in home care agencies trying to transmit all these documents between hospitals and admitting offices and home care agencies. I think it's something we need to capture if we're going to do an adequate job on looking at update factors.

DR. WAKEFIELD: Sharon, I had a question about looking at access related to home health care. You talked in our materials about service area mapping, some data that you're going to be using from CMS. Could you tell me a little bit more about how they're getting at the county level data?

That is, are they looking at home health agencies that are certified to provide care in a county? But at least anecdotally I understand that just because they're licensed to do that, for example, they don't necessarily.

And is there a way that you'd be able to tease out, for example, a home health agency that services seven miles into a county but they don't go 40 miles into a county? So how would that sort of a county look in this mapping? Would it be considered -- would one see that as services are provided, that county is covered because there's some penetration a few miles into the county? Or not?

Part of the reason why I'm asking you that question is because, at least in my region of the country, again anecdotally,

there's been some movement toward defining a catchment area as say 25 miles out from the mothership. And that's it. So if that 25 miles takes you all the way across the county, great. Not really in the part of the country that I live in, because the counties are much larger.

But how will that be reflected in that mapping that CMS is doing?

MS. CHENG: I think that's going to be actually one of the strengths of this map. VEVAC and I are working on this map. It is going to be based on zip codes rather than counties. So we're going to be able to look at a granulation that's at least a fair bit finer than county.

It also is self-identified by the home health agency, so it is going to improve our ability to describe the service area because we're not going to just drop a random pin where the address of the home health agency is and then draw lines from it.

CMS has asked home health agencies to identify those zip codes where they have or will serve patients. So that will reflect perhaps a home health agency whose nurses might live 50 miles from the agency and are willing to travel to that zip code.

So I think it's going to give us a pretty good picture of the service area. It will certainly raise questions about how many home health agencies serve that area? Maybe we'll be able to start to draw a picture of that.

The other reason we want to overlay population is to also get a sense, if we find a zip code that hasn't been identified as a service area what's the population of that zip, and then try to at least improve our description of it by adding that population covered.

I think it will be pretty good. I think it will be a good resource for us.

DR. MILLER: I just want to thank you guys. I'm really sorry that we railroaded you through this. And I appreciate the commissioners going along and being good sports about it.

I just would draw your attention just to two things in your packet, so that if you actually get some time to reflect on it, pages 23 through 25 have a good overview of the inpatient rehab, tells you the basic benefit, how many dollars, what the services are. Just if you want to familiarize yourself with that.

And then, of course, the hospice benefit, since we're kind of getting back into it, there's a lot of background in that section, starting on page 30.

Again, I appreciate this. I know that was tough to have to accelerate everything, but I really do appreciate it.

MR. HACKBARTH: Thank you.