MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Wednesday, January 14, 2004
10:19 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
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:

Home health: assessing payment adequacy and updating payments -- Sharon Cheng

MS. CHENG: In this presentation I'll review our evidence and discuss some new information in response to questions that you raised at our December meeting. I hope that I've addressed your concerns in the draft chapter and the materials that we'll discuss today. I'll start my presentation with a new recommendation for your consideration in addition to the recommendation that we discussed at the past meeting.

The idea of two recommendations is a pretty important one here because I think we will find that we have two issues on the table. One, is there enough money in the system to adequately cover the cost of providing care to Medicare beneficiaries? And two, are the structures of the payment system making some eligible beneficiaries less financially attractive than others and possibly creating access problems?

I think we could find that there is enough money in the system but at the same time certain types of beneficiaries are less financially attractive than others.

I'll start with the context for our recommendations. Current law is market basket minus 0.8 percent to be implemented on January 1st, 2005. Spending in 2003 for this benefit was $10 billion. The Congressional Budget Office projects that home health spending will grow 17.7 percent in 2004 and continue to grow at an average annual rate of 14 percent from 2005 to 2009 driven by continued growth in volume.

Another part of the context for making recommendations in this benefit is that the definition of this benefit is not clear. The benefit is not clear because it's not bound neatly by the coverage described in statute. By statute, the purpose of the Medicare home health benefit must be the same as the general purpose of all services covered by the Medicare program, the diagnosis or medically necessary treatment of illness or injury over a spell of illness.

However, precisely how the concepts of medical necessity and spell of illness pertain to home health care is less clear for this service than it is for others. In home health there are no definitive clinical practice standards to determine what treatments are necessary and for what kinds of patients they are appropriate. And the amount of service covered by the home health benefit for those who are eligible is fairly broad. It includes the skilled services necessary to treat patients, nursing and therapy, as well as ancillary, non-skilled or non-medical services that are necessary in conjunction with those skilled services to maintain the patient's health or facilitate their treatment.

However, unlike other services where the range of services is fairly broad, there is no explicit spell of illness for which Medicare coverage applies. Instead, coverage relies on eligible

criteria, whether a beneficiary is homebound, has a medical necessity for care, and needs care on an intermittent or part-time basis. However, here too the definitions of homebound and medical necessity are not explicit. Coverage decisions are made on a case-by-case basis by intermediaries who do not have clinical guidelines nor precise definitions of the criteria to work from. So as a part of the context for our discussion we're going to have a certain amount of ambiguity.

At our past meeting my presentation and materials were focused on aggregate measures, especially cost and beneficiary access. However, aggregate payments may be greater than aggregate costs and many beneficiaries may have access while the structures of the prospective payment system inappropriately encourage providers to serve some types of beneficiaries and discourage the services of others. The decline in use from 1996 to 2007 certainly suggests that we should be on the lookout for structural issues. The changes that were made in the mid '90s were intended to reduce spending and use of the benefit but not to exclude any group of eligible beneficiaries.

We also have evidence that there was a disproportionate decline in use among some types of beneficiaries. If some types of eligible beneficiaries have been excluded from the benefit because of the structure of the payment system then the system needs structural change and we should be on a track to look at whether there should be structural change.

We already know that three factors interacted to precipitate the decline in use. The Secretary initiated Operation Restore Trust in an effort to reduce fraud and abuse. It prompted the involuntary closure of hundreds of agencies that were not in compliance with the program's integrity standards and established civil liabilities for physicians who knowingly falsely certified the eligibility of a beneficiary. Through the investigations in Operation Restore Trust the Secretary found that fraud and abuse was not uncommon during the peak years of use.

Changing eligibility also had an impact on use. In 1997, the BBA clarified the acceptable frequency of visits and removed the drawing of blood as a qualifying service. Agencies reported that changing those eligibility criteria to exclude the drawing of blood decreased the number of users significantly in at least six high-use states. By defining the term part-time or intermittent the BBA narrowed its coverage of very frequent or nearly full-time care.

Changes in the payment structure also contributed to the decline. When Congress changed the law in BBA '97 and HCFA and CMS implemented those changes the new structures changes favored short-term recovery care over long-term maintenance care. The payment system gives a heavier weight and hence higher pay to providing therapy as compared to skilled nursing or aide service and is neutral towards the presence of a caregiver in the home.

Though decreasing use through reducing fraud and abuse or decline in use that followed a change in eligibility would not be cause for alarm, we should not be sanguine about the 1996 to 2000 decline because structural change may have made some beneficiaries less financially attractive which could have

impeded their access to care. MedPAC conducted two studies to determine whether the general decline in use was accompanied by the exclusion of certain types of beneficiaries. In both of our studies we focused on the characteristics of beneficiaries in 1996 as the peak year and then compared them to beneficiaries who used home health after the large decline in use.

In our first study we could not identify a particular type of beneficiary that had been excluded from the benefit. Rather, almost every type of beneficiary used home health care in 1996 and to some extent still used home care in 2001. So instead we looked at the likelihood of beneficiaries using home health care and then compared it to the likelihood of similar beneficiaries using the benefit in 2001. What we found was that those with a clear need for the benefit, which is to say that many or most beneficiaries of that type used home health care in '96, those types of beneficiaries had the smallest decline. Those with a less clear need, which is to say some of the type of beneficiary used home health but most did not even during the peak years, that group had the greatest decline.

We found mixed results in our second study. Two types of patients who may be less financially attractive were not disproportionately excluded from the home health benefit during the period of decline in use. Between 1996 and 2000 the average age and the level of functional disability of patients increased. These trends suggest that the older-old and the functionally limited were still using the benefit after the period of decline.

On the other hand, we found that the proportion of users who did not have a caregiver fell over this period. That latter finding is consistent with a decline in the number of home health aide visits provided by home health agencies. Because of the heavier weight given to therapy and the neutrality of the payment system toward the presence of a caregiver the types of beneficiaries who experienced disproportionate declines may be those who are less financially attractive.

So is structural change needed? I think that based on the evidence we have we have some mixed signals. Home health agencies may be serving fewer beneficiaries because of changing eligibility or program integrity oversight. If so, then neither changing the base payment nor the structure of the system would increase use. Alternatively, they may be avoiding some types of patients because they anticipate a substantial loss on those types of patients. Making a structural change by improving the outlier policy may improve access for this type of beneficiary, and we are studying the outlier policy.

Another explanation may be that they are avoiding some types of patients because those types are simply less profitable than other types. Now every prospective payment system is built on the assumption that some patients will be more profitable than others, otherwise we would have a cost-based system. But if subgroups of patients cannot get care or the providers who do care for them are disadvantaged by caring for them then a structural change would be necessary.

So to follow this track, MedPAC will examine the structure

of the payment system. We're going to look at the relationship between case mix and the financial performance of agencies. We're going to analyze two large demonstrations which broaden the homebound definition. We're going to extend our analysis of changes in the characteristics of home health users, especially their Medicaid status, their level of cognitive impairment, and their behavioral health issues. We're also going to study the outlier policy.

These additional steps also are necessary. The Office of the Inspector General will continue to monitor access to care for beneficiaries following hospitalization. CMS should continue the CAHPS survey as an important part of monitoring all beneficiaries access to care. And the Secretary should continue efforts to identify similar patients across post-acute settings and compare their use of care.

So on this track to pursue our concerns about beneficiaries who may be less financially attractive we come to draft recommendation one. The Secretary and MedPAC must continue to monitor access to care, the impact of the payment system on patient selection, and the use of services across post-acute care settings. Because of the exploratory stage of this recommendation I cannot quantify it's spending implication and at this point neither can I quantify the implications for beneficiaries and providers.

DR. NEWHOUSE: Sharon, since we're just monitoring why are there any spending implications or beneficiary implications? Those implications would arise if we did something based on the monitoring.

MS. CHENG: That's right. We could say none.

DR. WAKEFIELD: I don't recall that we've included references to MedPAC in other recommendations. Is there a reason why we feel compelled to recommend to ourselves here, rather than just making a recommendation to the Secretary? We assume that we're going to do this anyway, but why --

MR. HACKBARTH: I think you're right, Mary, so let's drop the reference to MedPAC. So we'll express our intent in the text by what we do. Good point.

MS. CHENG: On our second track then, we will consider evidence regarding aggregate payments and costs. Our first factor is beneficiaries' access to care. We found that most communities have a Medicare-certified home health agency. 99 percent of all Medicare beneficiaries live in an area that was served by least one home health agency in 2003. Most beneficiaries can obtain care when they seek it. Nearly 90 percent of beneficiaries surveyed about their experiences in 2000 reported they had little or no problem with accessing home health services. That percentage remained essentially the same in 2001 and 2002. The comprehensive geographic coverage and low rate of access problems suggests that access, in the aggregate, for most beneficiaries is good.

The next pieces of evidence that relate to whether aggregate payments are right are changes in volume. One measure of volume is the number of beneficiaries who use home health. Between 1996 and 2000 you can see the decline in the number of users. As time

passed without major changes to the payment system the total number of beneficiaries using the benefit grew for the first time in several years between 2001 and 2002. Both the Congressional Budget Office and the Office of the Actuary at CMS project that use will continue grow.

MR. HACKBARTH: Sharon, could you say just a little bit more about that? On what basis are OAC and CBO projecting that? Do you know what their thinking is?

MS. CHENG: They have a similar set of assumptions. They're not entirely aligned. In CMS's most recent report they noted that changes made to the homebound definition in one of the most recent pieces of legislation could lead to an increasing eligibility. They both note that the characteristics of the Medicare population would lead to higher use if the rate remained the same. They also see that there will be a growth in the number of episodes per beneficiary.

MR. HACKBARTH: I remember seeing in the early part of your presentation that CBO's projecting of an average annual increase in expenditures of 14 percent allowing a little bit for growth in the beneficiary population and a little bit for updates is in there. That's implying a fairly substantial increase in volume.

MS. CHENG: That's right. When we look at some other measures of volume we see volume actually starting to stabilize in 2001. Between 2001 and the beginning of 2003, the number of episodes per beneficiary remain the same, visits per episode decline only 1 percent and the average length of stay increased slightly. Thus, I think that the last couple of years suggest that the historically rapid changes are slowing. We have just entered this phase of moderate change and we should not try to extrapolate too far from what we've seen but it does seem to suggest that the phase of agencies rapidly reducing the services they provide within an episode is ending to be replaced by smaller changes.

The reduction in the volume of services was anticipated by CMS and GAO as the PPS was being developed. Both groups stressed the need to monitor the quality of care to determine whether the changes were improvements in efficiency or stinting on necessary care. MedPAC worked this summer to look at quality changes. The work we did with our contractor, Outcome Concept Systems, is parallel to the work by the Agency for Healthcare Research and Quality in their national health care quality report and to CMS's Home Care Compare.

To get a complete picture of quality at the agencies and to be consistent with CMS and AHRQ we included patients with Medicare primary payer as well as those with Medicaid. Scoring outcomes for home health is very new so we don't have much of a context by which to judge what the right score is. However these scores provide a baseline and allow comparisons over time. The median score for this quality index was .0.7 in both periods. The average outcome score rose slightly and the variation narrowed. Because we used all records for all patients to derive these scores we can conclude that the differences between those years were real and were not caused by sampling.

We could conclude that quality has remained stable at a good

level. For example, in 2002 for every clinical and functional indicator that we looked at such as shortage of breath or ability to move around, at least twice as many patients improved as declined, and sometimes three or four times as many. There was also improvement between the two years as the rate of emergent care and unplanned hospitalizations declined. However, on some measures there is room to improve. The number of patients who did improve as a percentage of those who could improve was less than 30 percent for five out of 20 measures in 2002.

The stability of this score has some implications for assessment of payment adequacy. There were concerns that as agencies reduce the number of visits they would cut out visits that were necessary to achieve quality outcomes. Instead we observed that the decline in the number of visits is concurrent with stable adjustable quality.

MR. DeBUSK: Overall, the prospective payment system for home health is this real successful? Is that the general opinion that the OASIS assessment system and all this?

MS. CHENG: I think there are a lot of people who are still looking at this. We're only three years into the system and as far as data we're maybe one or two years into the system. So I guess I'd rather call most people's opinions tentative than conclusive.

The next piece of evidence that we consider are costs over the coming year. The market basket for home health for 2005 is 3.3, and that market basket reflects the increases prices of transportation, nursing wages, and other inputs that affect the cost of providing an episode of care. Even though input prices have been rising over the past several years, the cost of producing an episode has fallen recently and there is no evidence that appears to suggest that costs increase.

We cannot disentangle the separate impacts of changing product of productivity, but we have estimates of their combined effect. Cost per episode fell 16 percent from 1999 to 2001 as the number of visits per episode was reduced by half. The rate of decline in the number of visits per episode continue at a much slower pace from to 2001 to 2002 but our 2002 sample of cost reports indicates that costs per episode continue to decline at 1 percent between those two years. Over the coming year we expect the slow changes to continue and do not expect costs to rise.

MR. HACKBARTH: Let me just make sure I understand the last part. Last year when we were making this decision we just had a partial year, 2001, partial sample of the 2001 cost reports which was a problem that we struggled with. So now we have the full year of 2001 and part of 2002?

MS. CHENG: Right.

MR. HACKBARTH: And when you look at the actual costs reported there there was a decline in costs per case from '01 to '02?

MS. CHENG: That's right. It's only one year.

DR. WOLTER: I had a question on this point too, because also in the body of the paper you talk about increased productivity. But I'm wondering if it's possible that the patient population or the product change is more the driver of

the cost improvements as opposed to productivity in the traditional sense.

MS. CHENG: Absolutely. That's why in this setting I haven't tried to pull apart product change and estimate that and then productivity and try to estimate that. What I'd rather do is just go with what I can observe and say some it's been product change and some of it's been productivity.

DR. NELSON: Kind of on this point because it has to do with product change. Sharon, first would it be useful to have some comparison between the kinds of services that are provided by an agency to their commercial business as compared to their Medicare business? For example, are some entities excluding certain Medicare patients from their services? It might be that they will provide IV antibiotic therapy at home for their commercial business but not for their Medicare business because of differences in payment.

And are agencies accepting commercial business with different payment policies than the PPS? Is there still a lot of their business, their commercial business, based on fee-for-service?

I think it would be really useful for us to use the private sector as some comparison to reassure ourselves that Medicare payment policies are appropriate. Is commercial business a big part of most agencies? Are there some agencies that don't accept any Medicare business because they have ample commercial business? And is the menu of services different depending on the payer?

MS. CHENG: We can give that a shot. One of the things that would make that difficult would be trying to find a group of patients on the private side that were comparable to the Medicare patients without -- we're not going to have a nice case mix adjuster over for our private group. We do know that home health -- Medicare is built on a medical model of home health care and a lot of the private services are home care. So while there's certainly a medical component, there are more home care components, light housekeeping, meal prep, that are going to be mixed in. So you're going to have a little bit of apples and oranges in trying to compare those two groups, but we can see what's out there to measure those two groups.

DR. NEWHOUSE: Would we have any information about agencies that don't take Medicare patients?

MS. CHENG: I don't know where we'd get it right off the top of my head.

MS. DePARLE: Otherwise all you have is who's a Medicare-certified home health agency, who participates in the Medicare program. Those numbers are hard enough, as you point out in the chapter, about how many are there, and how much changes there have been since the BBA. That's very hard to pin down. But I think the trade associations would have some sense of it maybe.

MS. CHENG: The next factor in our framework is a comparison of Medicare's payments and costs. In modeling 2004 payments and costs we incorporate policy changes that would into effect between the year of our most recent data, 2001, and our target year, 2004, as well as those scheduled to be in effect for 2005.

For the home health sector the 2004 estimate includes all aspects of current law including a decrease in the base rate that's scheduled for April 2004 of 0.8 percent. Our model generates a current aggregate margin of 16.8 in 2004, a slight improvement since the first full year of PPS. This margin suggests that the payments are greater than the costs of caring for Medicare beneficiaries. The distribution of margins from 2001, our base year, indicated that 80 percent of agencies had positive margins and agencies with positive margins provided 82 percent of all episodes to beneficiaries.

MS. BURKE: Could I ask a question on that? I went back to the chapter because I didn't remember seeing it so I don't think it's there. You can go to the next slide where you have reflected the variation between hospital-based and freestanding on a variety of issues. What we don't see are the margin differences. We see total margins for total delivery but not for freestanding as compared to hospital-based. Do we have that data? MS. CHENG: We do. Our margins are based on a complete set of freestanding agencies' cost reports. When we looked at cost reports from hospital-based home health agencies we estimated a margin around 3 percent.

MS. BURKE: I think that needs to be reflected in the text unless there's a compelling reason not to.

MR. HACKBARTH: Here again we have our usual issues about what does that mean and how the costs are allocated between --

MS. BURKE: Right, but if we're going to array all these other data points, case mix, visits, rural as a percent, then I think we ought -- because the issue will come up and has come up that in fact the margins are different. I don't know what it tells us from a policy perspective but it is a reality and it is a data point, if we're going to reflect the others.

DR. NEWHOUSE: I think the implication of this is that in fact it may be an accounting difference. I took the thrust of the argument in the chapter to be on other measures than the accounting measures they don't seem to be that different or we don't see why they can't be as costly. That was what I thought the implication was, or the argument was.

MS. BURKE: Certainly the case mix appears to be similar although freestanding seemed to be higher. Episodes, rural they're predominantly -- the hospital-based are predominantly rural. There's a variance there and there's certainly a variance in terms of --

DR. NEWHOUSE: But let me put it another way, you couldn't use these measures to account for a big difference in margins.

MS. BURKE: I agree. My only point is it is a factor. I don't know what it really means nor that we should do anything about it. But to state that the absolute of the margins are 16 percent when in fact -- and you do correctly, and I appreciate this, state that that is based on the freestanding -- I think the obvious question that arises is, all right, what is it for the other 30 percent?

MR. HACKBARTH: I agree with that, so let's put it in and then, along the lines of what Joe was just saying, it's not evident from data like these --

MS. BURKE: Why there's a difference.

DR. MILLER: Can I just make one comment on this? I apologize. What drove this whole thrust of the analysis were a set of questions we got here in December, and this comparison and all of that. I think our feeling about this, and I know there is frustration with this issue and we feel it as well. Our feeling about this is that using the hospital-based margins from the cost reports we get from the hospital are very misleading.

MS. BURKE: I understand.

DR. MILLER: So we did this mostly to make the point of they could very well be misleading. Some of my reservations in listening to this is, if we're going to get into the regular process of saying, this is what the hospital-based home health margin is, I think that's going to be -- I don't know if that's something we want to do. The whole reason we do the all-of-Medicare margin is because we don't believe the pieces of it.

MS. BURKE: I'm sensitive to that and I appreciate that there are huge issues with these numbers, not the least of which is the hospital cost report and how one allocates costs and all the other issues that are part of the whole debate about how one considers margins. But my concern, Mark, is that in this instance we affirmatively state a margin for freestanding. We have one-third of the agencies are not freestanding. It begs the question, having stated affirmatively it is a margin for the freestanding, what's the margin for the not? I know it brings all those other issues and I'm happy to have it footnoted, caveated, that the number is dog exhaust.

But the point is, it may not tell us anything about how real the number is, or that we ought to do anything about it, but I think to not state it leaves a question.

MR. HACKBARTH: I agree with Sheila. I think in terms of having our reports, coherent, understandable, I think this adds to them. It's a question. It's an obvious question. It's been asked by commissioners. It's been asked by other people. Rather than pretending it doesn't exist, we're better off addressing it explicitly. Saying, here's the number --

MS. BURKE: And say the number is not a number we're comfortable as really -- we can fully identify as being accurate based on the issues that arise because of cost reports and hospital-based activities. I personally am not prepared to -- I'm not asking you to do it so that I can then next time say, see, we ought to have done something for the hospital-based. I know you're fearful of that for good reason. Having stated a number, the number is a discrepancy, people say, okay, what's the story here? But I think not to state it leaves the question out there.

DR. NEWHOUSE: I have an alternative proposal, that we state it but we state a range that goes up to something around -- then the freestanding, with the argument that based on these data if one had some numbers that didn't include the arbitrary allocations a truer measure might be this. The case mix is actually greater in the freestanding, which would suggest that, if anything, the hospital margins might be greater than the freestandings.

MS. BURKE: Right; one would think.

DR. REISCHAUER: But doesn't that depend on what the payment is versus the case mix? The profit margin maybe is larger for simpler things than for more complex things.

DR. NEWHOUSE: But I'm assuming the case mix is calibrated to approximate the cost or at least on average is unbiased in these two entities. It may not be but that's why I wanted a range. There's a lot of uncertainty here, statistical. Just to put a point estimate of whatever it is, minus three or plus three for the hospital-based seems to me to be -- to really mislead. It seems to me a way to get around that is put in a range.

MS. BURKE: So, Joe, let me make sure I understand your proposal. Are you proposing that for hospital-based we give a range of, whatever the range is, zero to three or whatever is, and for the freestandings, similarly, we state a range that's X to 16?

DR. NEWHOUSE: Not the freestanding. Here's the argument. The argument is that we have a number we more rather than less believe for the freestanding. We have a number for the hospital-based that we don't believe, so if we just put in a number we would basically say, here's the number but here's why we don't believe you should attach any reality to this number, which seems like a strange way to go. Instead of that, if we're going to put in a number then say, but we think a better number than this number is something that approximates the freestanding number.

MS. BURKE: On what basis do we say that?

DR. NEWHOUSE: That's what I read as the thrust of the argument or the implication of these numbers.

MR. SMITH: No, the implication of these numbers is the one that Sheila is suggesting, that we don't trust the hospital number but given the cost reports it is the number we have. We are comfortable with the freestanding number.

DR. NEWHOUSE: The difference is both of these agencies are providing a service out in the home. The chapter makes that point so there's no particular reason why costs should differ between hospital-based and freestanding agencies other than these kind of factors.

DR. REISCHAUER: But let's imagine that 0.3 or three actually was the right number for hospitals and we have this freestanding entity that can do it a lot more efficiently. We would not argue that we should pay inefficient providers unless there's some particular reason why this needed to be performed in a hospital, which it isn't being performed in anyway.

DR. NEWHOUSE: That's also true. But the problem -- we encountered the same thing on the SNF side. So if we're going to maintain --

DR. REISCHAUER: But sometimes they're imbedded --

DR. NEWHOUSE: But there the site of service is the hospital in most cases. But still the general burden of the argument is that the cost number -- when you're allocating joint costs, costs don't -- what costs are we after? Are we after incremental costs of home health agency to the hospital? That's not the number we're reporting.

DR. REISCHAUER: But I can make a case for why hospital-

based home health would be more expensive because the labor agreement for nurses was part of a larger structure, the administrative structure was more complex and it's just a less efficient way of providing something. It's interesting but it should drive our payment policy.

DR. WOLTER: I would just say, it's kind of the eye of the beholder. You could also look at this data and say that since hospital-based have many more rural agencies, they're lower volume and therefore the overhead is higher per beneficiary leading to lower margins. You could choose to make many different arguments, but I think Sheila makes a good point. We put the number in. We don't really know what the real answers are today. But over time we probably due need to address what some of the differences are.

MR. HACKBARTH: We do disaggregate the data elsewhere, urban versus rural, and there's not a big difference as I recall on an urban-rural basis. So that wouldn't explain --

MS. BURKE: There is on volume.

MR. HACKBARTH: Volume is the more important predictor. But even then the lowest volume are still not as low as 3 percent.

MS. CHENG: No, they're 12.

MS. BURKE: But you could imagine transportation -- I mean, there are a lot of issues that presumably one experiences in a heavily loaded rural -- I don't know. I mean I don't know why they're different and I don't pretend to believe that they're necessarily accurate.

MR. HACKBARTH: So that's where I'd like to leave this. I think that we ought to include the data. We ought to explain why we're not sure that it's an accurate number. In addition to that, I would like to see us to make Bob's point that even if it were an accurate number it shouldn't necessarily drive payment decisions. So those are the basic points to include.

MS. CHENG: Within this context then using the evidence that we've reviewed I think we come to this conclusion on our second track. Congress should eliminate the update to payment rates for home health services for 2005. This recommendation would reduce spending by $200 million to $600 million over one year and by $1 billion to $5 billion over five years compared to current law. We believe that the adequacy of payments in the current year and over the coming year in the aggregate suggest that there will be no major implications for beneficiaries or providers.

With that I'd like to close my presentation and turn it over for discussion.

MR. HACKBARTH: Any other questions or comments?

I have a question and I guess it relates most to the earlier recommendation about monitoring and expressing concern about particular types of patients. I need some help remembering how the case mix system works. As I recall from the text, you say that patients with less well-defined needs may be less attractive financially because the system isn't adjusting for factors like their functional status and cognitive state. Did I remember that correctly?

MS. CHENG: Actually, their functional status is a pretty big part of the case mix adjuster, but their cognitive status,

behavioral health issues are not a big part of the case mix. So if those make the patient less financially attractive they're not a big part of the payment.

MR. HACKBARTH: What was the thinking behind the decision to exclude factors like that from the case makes adjustment? As a layman it seems like they may well affect the cost of caring for these patients.

MS. CHENG: I think that part of the issue when they were designing the case mix is that they were trying to build a case mix adjuster that was intuitive for the clinical practitioners in the field, and especially for some of the cognitive problems and for some of the behavioral problems there was a feeling that some of the practitioners weren't as confident about their ability to adequately assess a patient in the home. A PT may be much more comfortable with his or her ability to determine whether the patient has the ability to move around rather than a cognitive impairment. So part of that was, what was the consensus among practitioners in the field that they could really measure, that they could understand the care path for, and that would be an intuitive case mixer. So there were issues with some of those measures.

MS. RAPHAEL: Just to add to that, I think the other part of it was thinking about tasks that you could somehow concretize and capture and a rehab interaction is easier to capture.

Now I think I made this point and I think it's important and people should understand this, you could have a lower case mix in the system today and consume more resources. It's very, very possible and quite common, because if you have cognitive impairments, if you don't have a caregiver, then you have to put in more service units although the case mix doesn't capture that and you don't get paid for those additional units of service. That's why it is also possible that if you're in a market where you have higher demand than supply you could be choosing the cases where the case mix index better captures and rewards you for the provision of service.

So I think that is important to understand in all of this and it's why I support the need and am very glad to see it's reflected here today, the need to monitor access, the need to really step back, which is entirely appropriate. When we put in this prospective payment system we well understood that we were changing some of the incentives here and that we had to come back and modified it as we saw it implemented. So I think those areas really need to be focused on.

The other point that I wanted to make is that, I guess this is building on something that Nick said, I don't know where we are on quality. I would not move to say that quality is stable, because I don't think we're caring for the same patient group today that we cared for in 1999. So, yes, maybe rehospitalization, unplanned rehospitalization and emergent care has gone down, but that may well be because the number of congestive heart failure and COPD patients have dropped very dramatically, so therefore you're not getting the same rehospitalization rates.

So I'm just not as comfortable saying that quality is

stable. I don't know that it hasn't improved or that it's stabilized or it's decreased. I just don't think we know enough at this point because it's very much tied to the change in product and the change in the patients that we're currently seeing.

DR. ROWE: Carol, it's very interesting about the imperfections in the financing with respect to the resource needs per patient, but let me see if I can follow the logic because I'm not sure I get to the same place you do.

If the conditions that are required for your scenario are that demand exceeds supply, let's say there are 120 Medicare beneficiaries and resources to take care of 100 of them, and what you're saying is that if the payments are such that people are going to differentially avoid patients with dementia or something because they're going to get paid less then what we're going to have is 20 patients with dementia who didn't get into home health and that's going to be a subset that's easily defined.

But if that's not the case and if payment system were perfect across all diagnoses you're still going to have 20 patients who are Medicare beneficiaries who aren't going to get treated because the defining condition is demand exceeds, supply. You can only take care of 100. But instead of all having Alzheimer's they're going to have a variety of things. How are we better off?

So it seems to me that, yes, it's true that certain subgroups would be differentially disadvantaged but for any given patient it's that given patient. And the answer is that if demand exceeds supply then we should change payments or something in order to try to get a stimulus to get more supply.

DR. REISCHAUER: But there's one for condition, and that is for the dementia patients you have to be losing money if you take them on, not just making less money than you would if you took on somebody else. Then there's another question which you'd have to ask under your scenario is, what keeps this industry from expanding, if there is excess demand, when there's a 16.8 percent margin here on average?

DR. NEWHOUSE: On Medicare.

MS. RAPHAEL: That's a good question, why isn't there more entrants into the industry with this kind of margin? I think that is a good question. I would answer your question that I would increase my supply because it then would be worthwhile for me to perhaps pay more, et cetera.

DR. NELSON: Help me, Sharon, and perhaps Carol, so I don't climb up a wrong tree here. Is there any substantial risk of having payment policy create a two-tier system in which Medicare patients get a substantially inferior level of care in their tier? Or is Medicare such a dominant payer within the home care industry that that's not a concern? My comments were directed toward whether Medicare is being disadvantaged in competition with private business. I really don't know. I don't know whether the risk of a two-tier system is worrisome or not.

MR. HACKBARTH: On these facts, I don't think you would be worried about that. It's the Medicaid patient maybe that you would be worried about. But Medicare is paying well.

DR. NELSON: Medicare is just fine?

MS. CHENG: In the financial analysts' papers they routinely note that Medicare is the highest margin payer in the industry.

DR. NELSON: Good. Thank you.

MS. RAPHAEL: The total margins I believe, Sharon, are about 2.3 percent overall for the industry when you put the payers together. The most difficult subset are the dually eligibles or the Medicaid patients who tend to fit more into the complex case or the need for supportive care categories.

DR. NEWHOUSE: I want to go back to the issue on margins by line of business at the hospital. Let me make an argument that we basically don't want to present those numbers in any of the products. So let's first say for the sake of argument that we want to keep the hospital in business as a multi-product firm. So this is not the hospital that's failing. Then the issue is either the total margin or what we've called the most-of-Medicare margin. It's not the individual lines of business. We can and weekend and should present those numbers, and do.

Then when we now get to the product line we want to say, do we want to keep the hospital in business as a producer of whatever, home health, SNF, whatever? Then if anything, the cost numbers that would be relevant to that are the reverse of what we have in reality. That is to say, if you start with the assumption, which I think is reasonable, that the inpatient service is the service that's there first and these other services either are there or not there given that the inpatient service is there. Then the issue really is how much does it cost the hospital to add this extra service at some scale of business?

Under those assumptions you would allocate the joint cost to the inpatient side, and you would say it's just the incremental cost of adding home health that we should allocate to home health, and SNF, and so on. Now in fact what we've got is exactly the opposite. The hospital could push in as much of the joint cost as they can out of the inpatient side. So I think, as I say, the individual numbers are -- when we say we would like the true number, there really isn't a true number unless you go to this incremental definition which is far from what we have or could, I think conceivably get.

Whereas, the most-of-Medicare margin I think does have a meaning and the total margin has a meaning.

DR. ROWE: Are you suggesting that, therefore, for the different, as you call them, the different product lines, inpatient, outpatient, SNF, et cetera, that we not show those that all?

DR. NEWHOUSE: Yes. I just don't think that -- because it's inherently arbitrary where you put these joint costs, unless you want to say, you should basically put them over on inpatient, which is not anything like the numbers we have.

DR. WOLTER: I'll try to be brief because we're really not deciding this issue today I hope. But I would really disagree with that argument, Joe.

Number one, I think each of the of the key to the PPS systems is based on a system of averaging, but they weren't designed to be blended together. Even within one system we

currently have DRGs that are quite profitable and some that aren't, and there are decisions being made in terms of strategy and product line development based on that knowledge in the industry.

Similarly, we have other recommendations that suggest that we want different sites of care for the same thing to, roughly speaking, be given the same payment. So if we're not even tracking what happens in hospital outpatient, how do we have the discussions about ASC? I think there are so many problems with not charting a course in terms of our framework and philosophy that addresses this issue, wherever we go, that we could get ourselves into. But I think there would be many, many reasons to continue to try to look at the individual PPS system because that's how they were set up.

MR. HACKBARTH: In addition to that, one of the reasons why I don't think we can just whistle by this one is that the issue is out there, even if we don't choose to address it. For example, as I understand it, one of the differences between the industry's margin calculation and ours is that theirs includes the hospital-based agencies and they pull down the average with that.

I think we need to talk about this issue in this chapter this year and if we, for all the reasons that have been discussed, are skeptical about those numbers, don't think that even if they were right they would be the appropriate basis for payment policy, we need to lay that out. So as opposed to just saying, it shouldn't be there and we're not going to talk about it, we've got to talk about it.

MS. RAPHAEL: I think that's really important because the industry has done its own analysis and its numbers are quite different from the numbers that MedPAC has come up with. I do think we need to be able to explain what those differences are.

MR. HACKBARTH: We need to move ahead at this point so do you want to go to the other recommendation? We'll make the editorial change suggested by Mary. All opposed to this recommendation raise your hand. All in favor? Abstentions?

Then on the update recommendation, all opposed? All in favor? Abstentions?

Okay, thank you, Sharon.