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:

Skilled nursing facility services: assessing payment adequacy and updating payments -- Susanne Seagrave

DR. SEAGRAVE: Good afternoon. I will now briefly review the evidence regarding SNF payment adequacy for fiscal year 2004 and present the draft update recommendation for fiscal year 2005. Since you've seen most of this at previous meetings I will be brief.

The evidence we have suggests that most Medicare beneficiaries have access to SNF services but that certain types of patients with special needs, such as those who have diabetes, need ventilator support, are morbidly obese, or who have special feeding requirements may stay in the hospital setting longer before they go to a SNF. We don't know if this is a good or bad outcome for these patients. However, this finding may point to problems with the distribution of payments in the SNF payment system, and we'll return to this point later when we discuss the second draft recommendation.

In terms of supply, the overall supply of Medicare-certified SNF facilities and SNF beds appears to have been pretty stable since 1998 with the total number of Medicare-certified SNF facilities declining by less than 1 percent between 1998 and 2003. As you can see from this graph, the number of Medicare-certified freestanding SNFs has grown pretty steadily since 1992. This is the yellow line. The number of hospital-based SNFs, however, peaked in 1998 and has declined each year since.

From 2002 to 2003, the most recent data we have, the number of Medicare-certified freestanding SNFs grew by about 2 percent and the number of hospital-based SNFs declined by 9 percent. Note that Medicaid-only nursing homes, that is nursing homes that do not serve Medicare SNF patients, are not included in this graph because they are not relevant to our discussion. Their numbers have been declining in recent years.

In 2001, the most recent year for which we have data, the volume of SNF services grew with discharges increasing by 6 percent, the number of covered days increasing by 8 percent, and the average length of stay increasing by about 2 percent.

Evidence regarding quality of care is mixed. I want to pause here for a moment and discuss this a little bit since it came up at the December meeting. Most of the evidence we have regarding quality of care in SNFs is from the year 2000 and before and much of it comes from studies of overall nursing home quality rather than quality of care in SNFs specifically. Recall that about 90 percent of all SNFs are located within nursing homes. We generally assumed that nursing home and SNF quality are related.

Overall then, studies of patient care in nursing homes have tended for many years to find room for improvement in the quality of care delivered to nursing home residents. In addition, some studies have suggested that nurse staffing levels in nursing homes declined and the number of reported deficiencies in nursing

homes increased between 1998 and 2000, the years immediately following the SNF prospective payment system. Studies of patient assessment data, this is data on functional statue of beneficiaries between 1998 and 2001, including MedPAC's own analysis of adjusted rehospitalization rates, found mixed results for quality. A GAO report provides the most current evidence we have showing that the overall number of serious deficiencies in nursing homes declined somewhat between 2000 and 2002.

Given this mixed picture what can we do to improve the quality of care in SNFs and in nursing homes? The first thing we can do is collect more information with which to study quality in this sector and its relationship to payments and costs. Our third draft recommendation which I will turn to later, addresses our need for better information in this respect.

The next thing that we can do to improve quality is to improve quality outcome measurement which is still not well enough developed in this sector. MedPAC, CMS, and others are working together to come up with better quality outcome measures. Once we improve the quality measurement then we can measure implement financial rewards for SNFs that provide better quality.

The evidence regarding SNF's ability to access capital is similarly mixed this year. CMS's annual analysis of the nursing home industry suggested that access to capital worsened in early 2003 due in part to uncertainties surrounding Medicare and Medicaid payments. However, nursing homes Medicaid funding situation for this year at least appears to be improving. Recent reports by both the Kaiser Commission on Medicaid and the Uninsured and GAO suggests that Medicaid nursing home rates remained relatively stable in 2004, although both sources allude to possible changes down the road if states' budget crises continue to worsen.

Finally, some large for-profit nursing home chains reported higher than expected earnings growth at the end of 2003 which also helped the sector's financial outlook. With respect to Medicare payments, nursing home industry analysts generally view these as favorable for the industry.

Now we turn to the Medicare margin. We project the Medicare margin for freestanding SNFs to be about 15.9 percent in fiscal year 2004. I want to note that we just got updated data that may lower this by a percentage point or so. This follows an 11 percent Medicare margin for 2003, a 16.7 percent Medicare margin for 2002, and a 19 percent Medicare margin for 2001. This is for freestanding facilities.

The Medicare margin for 2004 is higher than the Medicare margin for 2003 in part because SNFs received the full 3.0 percent market basket update for 2004 plus an additional 3.26 percent payment increase which represents an administrative action by CMS to correct for market basket forecast errors that occurred in previous years.

MS. DePARLE: Susanne, so what's missing from this is 2003 is 11?

DR. SEAGRAVE: Yes. I could have put that on the slide. Last year we projected the 2003 margin to be 11 percent, and that's still what we project this year.

MS. DePARLE: And 2004 is a projection as well?

DR. SEAGRAVE: Yes.

MS. DePARLE: But 2002 and 2001 are actuals?

DR. SEAGRAVE: Yes. To give you an idea of the distribution of Medicare margin across facilities, we found that about 88 percent of Medicare bed days in 2001 were in positive margin facilities. The Medicare margin for hospital-based SNFs is difficult to measure correctly because of hospital cost allocation issues, as you discussed in the previous discussion. We estimated the Medicare margin for hospital-based SNFs in fiscal year 2004 to be negative 77 percent. However, we are unable to determine what this number means in the context of an efficient provider.

As we've discussed before, freestanding SNFs generally responded to the SNF prospective payment system by reducing costs. We expect this trend to continue into 2005. Furthermore, although nursing wages may have increased for SNFs in recent years because of the nursing shortage, costs may not have risen by as much as wages to the extent that SNFs substituted lower skilled for higher skilled labor. In addition, data by the Bureau of Labor Statistics suggests that nursing wage growth may be stabilizing.

Finally, we are aware of only one cost-increasing, quality-enhancing technology in this sector, vacuum assisted closure, the so-called wound vac for healing wounds. We do not know the extent to which SNFs are adopting this technology because of the incentives in the SNF prospective payment system.

Finally, we believe these cost changes in 2005 can be accommodated within the margins SNFs already have in 2004. Therefore, we recommend that the Congress eliminate the update to payment rates for skilled nursing facility services for fiscal year 2005. The update in current law is market basket which is currently estimated at 2.9 percent for fiscal year 2005, and this estimate, of course, is subject to change each quarter.

Within the budget categories that MedPAC has developed, a zero update for SNFs would decrease Medicare spending relative to current law by between $200 million and $600 million in one year and between $1 billion and $5 billion over five years. Because we project the Medicare SNF margin to be 15.9 percent for 2004, we do not anticipate major implications for beneficiaries or for providers of this recommendation.

However, we would like for this overall pool of money to be better distributed across the different types of patients cared for in SNFs. Thus, we reiterate our recommendation from last year which is intended to improve access to SNF care for those types of beneficiaries I mentioned earlier that may be having difficulty accessing SNFS, and distribute money more accurately among providers.

We recommend that the Secretary develop a new classification system for care in SNFs, and because there needs to be a more immediate fix to the distribution of money in the SNF payment system, the Congress should authorize the Secretary to remove some or all of the 6.7 percent payment add-on to rehabilitation RUG groups and reallocate money to the non-rehabilitation RUG

groups to achieve a better balance of resources in the system.

As we added this time again, if necessary action on this does not occur by October 1st, 2004, the Congress should provide an update to payment rates for hospital-based SNFs of market basket minus 0.9 percent adjustment for productivity.

The portion of this recommendation that deals with hospital-based SNFs would decrease spending relative to current law by less than $50 million in one year and by less than $250 million over five years. The other part of the recommendation we assume would be spending neutral. This recommendation as intended would potentially provide better access to SNF care for certain types of beneficiaries and more accurately distribute Medicare payments among providers.

Finally, so that we and others may better study the relationship between nursing costs, total costs and quality of care in this sector we recommend that the Secretary direct SNFs to report nursing costs separately from routine costs on their Medicare costs reports. Facilities in some states are already doing this. This recommendation has no spending impact, would have no effect on beneficiaries and would likely mean a modest additional cost for providers.

This concludes my presentation and I welcome any questions you may have.

MR. DURENBERGER: Thank you very much. My question is going to relate to quality. The basic question is, we've been talking about paying for performance and things like that, and my concerns -- I've skipped my concerns about cross-subsidizing Medicaid and all that sort of thing so this really relates to whether or not changing payment or increasing payment actually have or can have an impact on integral quality. In other words, if you were going to pay for performance in the sub-acute system, what would you pay for and how would you construct the system? The only distinction I could gather from some of this material, and I may have misinterpreted what you presented was, pull out the routine cost from nursing costs and some things like that.

But I know the National Quality Forum has been working on measures. I know that Tom Scully thinks he's got measures. I know that he's been advertising that you can call a number and rate this nursing home versus -- but I still don't get what's quality when I -- and I haven't tried to call the number, but I'm still not sure of what the definition of quality is. But more importantly, what role payment or payment policy has as it relates to the quality. Can you help me understand that a little better?

DR. SEAGRAVE: To start off maybe with your second point, I think we are still struggling with what quality means in this sector. I think that's why we still have to develop better quality measurement in order to be able to reward providers that demonstrate better quality.

MR. DURENBERGER: Does that mean better measurements than the ones that allegedly the National Quality Forum produced, or am I misinterpreting what they did last year?

DR. SEAGRAVE: I think in terms of whether the government can use the measures that the National Quality Forum developed,

whether Medicare's purpose for those measurements would be the same as the National Quality Forum's purpose, those kinds of things I think still need to be worked out. So I think we're still a little ways away maybe from having the type of quality measurement that we might need to be able to reward quality.

Then getting to your second question about the relationship between Medicare payment and quality, I think there have been many -- I'm glad you brought that up. I think there have been many studies recently about the relationship, not just between Medicare payment but between financial performance in nursing homes specifically and quality. I think that those have shown that the relationship is not very clear, and in fact a recent study showed that for-profit nursing homes in California that have greater than 14 percent margins actually display lower quality in terms of the number of deficiencies that they show. So I think that there's not a clear-cut relationship between payment and quality and that's why I think breaking out the nursing costs from the total costs and looking at that, and looking at payments and costs and quality relationship, I think more work needs to be done.

MR. DURENBERGER: I'd just summarize by saying, just as a layperson who uses the system for family members, I'm very confused when I hear the word quality being used by the administrator of CMS and a lot of people, and I'm not sure that we really know what we're talking about. Yet when I sit here to try to make a judgment on payment adequacy I'm more inclined to think about quality than I am about access because I think it seems like we've solved a lot of the access problems, or at least some of the access problems, some substantial part of the access problems, but I'm not sure about the quality part. So I'm left unsure about how to deal with that and I would interpret your answer as saying, at the present stage we don't have much to be helpful to you, if that's your questions.

MR. HACKBARTH: In this context where we have high average margins, adding more money to the system is not a very powerful tool for trying to improve quality I think is one of Susanne's basic points. They've got enough money now. The incentives are to reduce costs. If you really want to improve quality you would be better off identifying what you regard as improved quality and paying specifically for that.

MR. DURENBERGER: That's precisely why I asked the question.

MR. DeBUSK: Glenn, are we adding or are we taking away? You said by adding more money.

MR. HACKBARTH: This recommendation is for no update.

MR. DeBUSK: No update. But the update is designed to keep up with the cost of services provided from year to year, right?

MR. HACKBARTH: And they have average margins of 15 or 16 percent currently.

DR. MILLER: Just a couple other things on the quality point. I'm going to need some help here so if Karen and Susanne can both follow me here. There are people mining the MDS data to look for quality measures and that is part of CMS's effort; is that correct?

MS. MILGATE: Yes.

DR. MILLER: And then there's the notion of nursing home quality measures which I think some other groups are mining those measures. I'm just looking for a nod or a clarification.

MS. MILGATE: CMS is looking at nursing homes too.

DR. MILLER: Just to be clear, that's distinct from SNF. We ourselves are looking at some readmission indicators; is that correct? And we're would going to be doing some analysis on the relationship between cost and quality down the road.

DR. SEAGRAVE: That's correct.

MS. RAPHAEL: I happen to believe that one of the most important areas of quality in nursing homes happens to be staffing, and that while you have a 100 percent turnover rate in CNAs and if you don't have the nursing staff it's just going to be very hard. It's one of the few places where I feel inputs are probably as important as outcomes. So I'm wondering if we're looking at that in the work underway.

DR. SEAGRAVE: Certainly. The CMS web site, they report staffing levels by nursing facility. We're looking at costs and quality and staffing levels, because I think there have been a number of studies on the relationship between staffing levels and quality in nursing homes. I think we're continuing to look at that and try to find out what's going on there.

MS. RAPHAEL: Do they report retention rates?

DR. SEAGRAVE: No.

MS. DePARLE: As I recall that's really difficult to get.

DR. MILLER: Susanne, that's one of your motivations for the third recommendation, is to try to break out the nursing costs as separate. Not perfect, but to begin to drive in on how much of their resources are going to nursing and whether there's a relationship between that and equality.

DR. ROWE: Carol, when you say 100 percent turnover, if there are 20 nurses --

MS. RAPHAEL: No, CNAs.

DR. ROWE: All right, let's take them. Do you mean that all 20 of them change, or that maybe 10 of them stay the same for years and years and years and the other 10 slots turn over a couple times a year? So you've had 20 turnovers; i.e., 100 percent turnover, but in fact you still have a core of people who are there for -- what do you mean when you say 100 percent?

MS. RAPHAEL: I don't know for sure because I'm not sure there's consistency in how --

DR. REISCHAUER: It's almost always the latter.

DR. ROWE: That's what I think. So the turnover rates exaggerate the impact a little bit maybe.

MS. RAPHAEL: Although I think they're very high in the first six months from what I remember.

DR. ROWE: When people learn what the job is.

MR. SMITH: Just quickly I want to underscore Carol's concern on the nursing side of this. It's not just a question of nursing costs or share of costs allocated to nursing but something about staffing, something about training, something about turnover, and turnover up and down the hierarchy matters a lot. I think, Bob, you're right that it tends to be some stable, some turnover a lot pattern, but that's not within the same job

category. At entry level job categories the absolute turnover is higher and supervisors tend to be more stable.

Just a quick quibble on recommendation two. It seems to me we ought to make sure that the recommendation says that we're talking about the same money in the second bullet that we're talking about in the first and we don't. We could be talking about two different chunks of money. So it's only the money, or reallocate some of the money or some such change.

DR. REISCHAUER: My question dealt with the same issue. Susanne, I was wondering if we had any kind of feel for if the first part of the recommendation occurred what it would be equivalent to as an update for hospital-based SNFs? I didn't know if these two things are different ways of doing very similar things or one is, let's go for a vacation and if we don't go for a vacation, let's buy a car. Are hospital-based SNFs heavily into non-rehab RUG services or not? Because if they aren't it's sort of like, does this really connect?

DR. SEAGRAVE: I think it's hard to determine -- across the board it's hard to say if they're more into rehab, more into non-rehab, those kinds of things. I think that the recommendation is designed to more accurately distribute payments among different types of providers, and to the extent that a particular hospital-based SNF treats a higher proportion of non-rehabilitation patients then it is designed to funnel more money to them. But I think it's still an open question whether hospital-based SNFs are treating a higher proportion of non-rehabilitation patients.

DR. REISCHAUER: So it's conceivable that if the first part of the recommendation happened it wouldn't do anything for hospital-based SNFs.

DR. NEWHOUSE: But going beyond that, to raise whether we want the second part of the recommendation at all.

DR. REISCHAUER: It might hurt them. Without knowing that it strikes me that either they should be two separate recommendations or else we should be careful about what we're suggesting.

DR. MILLER: I thought, and again I could have missed something in the process here. I thought that at one point we had some indication when we were looking at case mix differences between the two that there was some thought that they were more heavily mortgaged in the non-rehab. Is that not the case?

DR. SEAGRAVE: I think we think they are treating a higher case mix of patients. I think that there's some indication, although it is based on older data, that they are treating a higher percentage of non-rehabilitation patient. But getting the more current data and figuring out whether that's still the case or not, I'm basically not willing to go out on a limb right here in front of everybody and say that they definitively are at this point.

DR. MILLER: That's appreciated. But when we drafted this up last year we had some thought in our mind that it would be redistribute it. But you're saying, to be completely careful about it you would want to see the most current.

MR. MULLER: Would you remind me again what the distribution is between the profits and not-for-profits in terms of their

rehab share? I seem to remember from last year we had some numbers on that. Weren't the rehab services higher in the for-profits than the not-for-profits?

DR. SEAGRAVE: I honestly don't remember that data from last year. That would be my guess.

MR. MULLER: I seem to remember we had it before so that should be retrievable as opposed to a new --

DR. REISCHAUER: If that isn't the case we have to rethink capitalism.

MS. BURKE: Two questions. One, on the issue of nursing and the third recommendation, which I think is terrific, one of the questions that ought to occur once we actually separate these things out is some understanding of what we mean and the differences in what nursing is. Nursing costs as stated will include a broad range of what are defined as nurses. The question, and in fact there is research on this topic and some data available on the impact of the presence of professional nurses. Is that the word we use now? Registered nurses, whatever the word is that we currently use, that there is in fact a direct impact of the presence of registered nurses as compared to a broader array of nurses.

So one of the things I would hope we'd be able to do as we develop this information, or if we can understand if there is in fact that difference, is it just nurses, nursing cost, money spent on X more LPNs or X more aides, or is it in fact -- does it differentiate if in fact the money is spent on fewer but they are registered nurses as compared to nurses aides? Just for purposes of understanding what that impact intent is.

The second question is, at the risk of getting back into the conversation about margins, nonetheless on page 14 we again avoid the obvious question and the specifics by stating that the aggregate Medicare margin for hospital-based SNFs remain slow. What I think I heard you say was that it's negative 77 percent. That is certainly a definition of low. But again, they will ask the obvious question and the question is, do we address it directly or do we not? But I think just simply referencing low and a statement of margins that are in the 15 and 16 percent, whatever it is versus a negative 77, one might think we might want to explain once again that there is a number there that is not a number we're solid with. But it will just lead to the inevitable question, what does low mean? You've stated it affirmatively for freestandings. We know what it is. What does that mean?

So again, I don't want to get back into that debate but I think we need to be -- the question is going to come so we may as well be prepared to deal with it one way or another.

DR. NEWHOUSE: I was going to let Bob's other shoe drop. Should we take out the last part of two, not only because we seem to lack data but also because even if we had data showing differences, as Bob said on the home health, it's not clear we would want to pay for it.

DR. REISCHAUER: My question is whether we shouldn't break up recommendation two. The first part of it seems to be, let's get the distribution of payments better. We don't know if that's

going to help hospitals or isn't going to help hospitals. But if we think there's a problem in hospitals then we should have a recommendation saying hospitals should have some kind of an update. If we're concerned about the overall level what we should say is, we should take the 6.7 percent payment add-on, take a chunk of that to distribute across payment categories to make them better, and take another chunk of it and use it for a hospital-based SNF update.

DR. NEWHOUSE: Why do you want to do the latter?

DR. REISCHAUER: Why do we want to do the latter in this recommendation now?

DR. NEWHOUSE: I don't know.

DR. REISCHAUER: Presumably because we think --

MR. SMITH: This recommendation at the moment, Glenn, I had wanted to go to the same place -- suggests that we know something about the distribution of non-rehabilitation patients, that they are skewed toward -- otherwise this recommendation doesn't make any sense. We're going to shift the money from rehab groups to non-rehab groups, but if we can't, we want to give money to hospital-based SNFs. We have to assume, Mark, that there is a distributional of relationship as your remembered, but we don't recite it anywhere here and there's been -- this discussion makes me wonder whether or not the only recommendation that we really have any grounds to make is the last part, I think which is where Bob was going, the last part of what is now two. To remove the 6.7 doesn't make any sense.

DR. MILLER: If I could just say one thing on the 6.7, regardless of what we thought was going on in hospital-based, we believe that the system as it's currently constructed in terms of the relative weights the money should be redistributed, and that the money will better track the patient. So regardless of where they ended up, hospital-based or non-hospital-based, we think that should happen, on the basis of analysis that we've done of the payment system.

Now rightly or wrongly last year -- and I'll take responsibility for this -- in looking at case mix we thought there may be something to the story that they may be taking more of these patients, and made the point that this redistribution may help those hospital-based SNFs. I think Susanne is beginning to say, I need to be sure that that's still the case so we may be walking away from that.

I think this recommendation, the redistribution stands on its own merits. We've been over this ground. I think the question becomes what to do about the second one.

MR. SMITH: But the second one is now offered as an alternative to the first one, suggesting that we're trying to accomplish the same thing. We clearly shouldn't do that.

DR. MILLER: The linkage should not be there. I agree with that.

MR. SMITH: So if there's a justification for the second half of recommendation two as drafted it is that we think that hospital-based SNFs are in some trouble.

MS. RAPHAEL: But the rehab data, as I remember, showed they had shorter length of stay and higher case mix and higher nursing

staff. That's what I remember. I don't remember information about rehab and the degree to which they provided rehab.

MR. SMITH: No, but I think that's exact -- or at least we're uncertain about that, Carol. So that suggests that even if we accomplish the desirable redistribution among RUG groups that we have to then ask ourselves, do we have an institutional issue here which suggests that for whatever reasons hospital-based SNFs need additional resources? I don't know that we've made that case here.

DR. NEWHOUSE: I want to go back into history. In the early 1990s entry conditions for hospital SNFs were especially favorable. You could get your costs back, and they expanded very rapidly. What we've seen post-BBA is a considerable contraction in the for-profit hospital SNFs, which just suggests to me that for-profit firms were pursuing profit in the early '90s. BBA took it away and they exited. It's not clear to me that there's anything bad at the end of the day from all of this.

I think there's a downside to this recommendation even beyond trying to fix up the SNF side in a way that may or may not be very good, which is that we're going to reintroduce differential payment rates according to site of care, which is, I think, a principle we don't want to do.

MR. HACKBARTH: So, Joe, your proposal would be to drop this --

DR. NEWHOUSE: To strike this last clause and go with the first part.

DR. REISCHAUER: To be fair, what we should do is split them and vote on it, rather than --

DR. ROWE: With respect to your historical, I think payment had something to do with it, but one of the other things was that length of stay was falling in hospitals. Occupancy rates were way down. There were lots of empty wards. There were resources in search of needs. There were people trying to figure out how to use those facilities, and that fed a lot of the development of hospital-based SNFs.

DR. NEWHOUSE: The one reason length of stay was falling was one could unbundle the DRG payment, put the marginal day over in the SNF.

MS. BURKE: I'm perfectly comfortable splitting these. I think that makes perfect sense. But before outright rejection of this last question, and not necessarily this proposal but the issue of hospital-based, I think some thought -- I'm almost hesitate to suggest we even vote on this. I wonder if we shouldn't set it aside rather than defeat it, and get a better understanding of what the issue is that we're trying to deal with. There are geographic issues. There is a predominance of these folks in rural areas. What implications that has, I don't know.

Joe's point about the rapid increase in the number of home health agencies in the early '90s is absolutely right. Whether or not what remains are predominantly for-profit, whether it's just all the for-profits that have left that would suggest it's just a question of whether there's profit or not, I don't know the answer to that question without looking at -- but Joe may

have a very good point.

But I think there's an issue here, a minus 77 percent margin would suggest there is an issue. I guess my preference would be to understand that more clearly before we reject out of hand that there's initiative there that needs to be dealt with.

MR. HACKBARTH: I agree with that, Sheila. Rather than defeat it on an uncertain factual basis I would just say, let's take it up at a later date, get some more facts and set it aside for now. So the proposal on the table would be to vote on the reallocation proposal only.

MS. BURKE: Could we accompany that -- what I would also not want to do is leave it unstated that there is an issue at least the Commission is interested in pursuing, and that while we have not adjusted in those go-round that it is our intention to examine more carefully. So I think the document ought to reflect, the issue has arisen. We chose not to address it here in the absence of information, but in fact we specifically intend to do so.

DR. SEAGRAVE: Can I just add to this conversation just quickly? We have two major research projects going on right now with outside contractors, both of which are devoted to studying hospital-based SNFs and what happens in areas where hospital-based SNFs close, and what the products that hospital-based SNFs are delivering is. So we have that, plus we are also doing a really serious look at hospital-based SNF costs. So all three of those.

DR. WOLTER: This would be anecdotal, but in my own experience with hospital-based SNFs in my part of the world in fact the physicians putting patients there are choosing patients they wouldn't send to freestanding SNFs because in their assessment they're more fragile, need more resource. Also I would say, and this is just my own institution so it's an N of one, we have different standards around nursing ratios and mix of nurses and those sorts of things. So I think that at least in some cases there is probably something different going on.

Then back to this overall Medicare margin discussion, if we're concerned about hospitals' overall Medicare margins, how do we decide to fund a full market basket in inpatient and outpatient versus SNF versus whatever? That's why I'm a little bit concerned about where we're headed with this, because it may be that in fact the overall Medicare margin in hospitals is in some decline in part related to their SNF margins as opposed to inpatient or outpatient. So I worry a little bit about how we make these decisions as we start lumping everything together.

MR. HACKBARTH: What we can say is that as a proportion of the overall book of business, the hospital-based SNF is a very small fraction of the total. I don't know those numbers off the top of my head but it's just a couple percent.

DR. SEAGRAVE: 2 percent.

MR. HACKBARTH: About 2 percent. So it can't be a principal driver of what's happening to the overall margin. It's just not big enough.

MS. RAPHAEL: I'm sure all of us have received a lot of material and I just read some of the material I received from so

of the people in the nursing home sector and they made the point, which I just think we should go back and check and I will give to you, Susanne, that they are already reporting nursing costs apart from routine costs in line 16 of some form, and all the rest of that. I'll pass this on because we just ought to confirm that it's not --

DR. SEAGRAVE: I'll tell you that I've spoken with some experts on the SNF cost report and I and the experts I spoke with do not believe that's what's currently being reported or what is going to be reported on the SNF cost reports, is getting at exactly what we want to understand. So I'm actually going to discuss that with --

MS. RAPHAEL: We should put it in the text probably too.

MR. DeBUSK: Nick, in the allocation of overhead at your institution is that not done on a square footage basis? So a nursing home owned by your operation, it could be sizable then, right, from a dollar standpoint?

DR. WOLTER: In our case the SNF is located on-site so it's the size of a nursing unit in essence.

MR. DeBUSK: You say that's 2 percent?

MR. HACKBARTH: We're talking about overall. Not all hospitals have hospital-based SNFs, but --

MR. DeBUSK: Yours could be considerably higher then, right?

DR. WOLTER: This whole accounting issue, I believe needs to have a little light shed on it. I would just say this, I don't think that we're doing any arbitrary allocation of costs to SNF or anything outside of inpatient. It may well be, however, that our overall overhead for the institution, the indirect costs, are higher than it might be for a freestanding, smaller operation. Therefore in the allocation methodology more costs end up getting allocated. I assume that's at least part of what goes on. But I just can't come up with any information anymore suggesting that hospitals are arbitrarily allocating costs from inpatient to outpatient. I just don't see that in my life.

DR. NEWHOUSE: When I said arbitrary, I meant just a convention that could be a different convention that would lead to a different allocation. So square footage, in my view, is an arbitrary way to allocate cost. It can be consistent over time, and that's the rule. You could allocate it in some other fashion that would lead to a different allocation. I would go on and add, if the Commission pursues this, I think it ought to try to get some measure of direct costs for these various lines of business. That is, the costs before any allocations are made. That I think would be -- that has some meaning as a number to look at.

Now the indirects have to be covered in some fashion, which gets you to the most-of-Medicare margin, but that's not what we have now.

MS. BURKE: Can I ask a question? Remind me what we do with swing beds currently.

DR. SEAGRAVE: The swing beds in critical access hospitals are not covered under the PPS, and those are not included. I believe other sorts of swing beds were first included in the PPS,

I believe starting in 2002, so our data for the most part still has not included them. I'm not sure what we're going to do about them next year. I'm not sure if they're going to be somehow -- anyway, the short story is I don't think they're included in our analysis at the moment.

MS. BURKE: And the prevalence today swing beds? How many hospitals actually --

DR. SEAGRAVE: I could get back to you on that. I don't know that --

MS. BURKE: I don't know whether their experience will lend us any knowledge about the nature of the hospital-based nursing home patient. I mean, understanding what they look like, how they're dealt with. Arguably, they would be comparable, presumably, to any other hospital-based unit, skilled unit. It's just the hospital's choice of how one structures. But I don't know whether any understanding -- just as you're looking at this issue and giving the studies that are going on, I don't know whether that would inform us at all, but it would be interesting to know what the nature of those folks are and whether there's any comparability.

DR. SEAGRAVE: I will tell you that what I've heard a lot of people say, particularly actually in rural areas, is that it's easier for them to, perhaps to close their hospital-based SNF and just have swing beds. that makes it easier administratively.

MR. HACKBARTH: Last comment.

DR. REISCHAUER: Just a question. What happens in critical access care hospitals? The SNF is a separate unit, right? But we're talking about possibility in the past of shifting administrative costs onto the cost-based reimbursement and now we've gone the other way, so you could see a lot of the administrative costs --

MR. ASHBY: In the past they have not been allowed to have SNFs so it really hasn't been an issue for critical access hospitals. They do have swing beds, of course, so it's the same issue.

MR. HACKBARTH: Let's go back and vote on the recommendations. All opposed to recommendation one? All in favor? Abstentions?

All opposed to recommendation --

DR. NEWHOUSE: Just this much of it?

MR. HACKBARTH: Just this much. We're dropping the part about the market basket increase for hospital-based SNFs as an alternative. So it's just this piece.

All opposed to this? All in favor? Abstain?

I think that's it then, right?

DR. NEWHOUSE: Number three.

MR. HACKBARTH: That's right. All opposed to number three? All in favor? Abstentions?

Okay, thank you.