MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

**Friday, October 10, 2003**
**9:02 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
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:**

**Preliminary information on home health market factors**
**-- Sharon Cheng**

MS. CHENG: Hello. This presentation is the first of three to develop our update recommendation for the home health sector for this year. Today I will cover three factors, beneficiaries' access to home health services, entry and exit of agencies from the program, and the agencies access to capital.

In my next presentation I'll be adding information on the volume of services and the relation of payments to costs. I also planned, in my next presentation, to add a new indicator of quality which I'd like to introduce to you today.

By way of context, I'd like to start with a description of the home health sector. This table shows you the composition of the 7,000 or so Medicare-certified agencies in terms of the number of agencies. The categories refer, in the first case, to whether they are freestanding or whether they are based in a hospital, SNF, or other health care facility. In a second case it refers to the location of agency. And in the third case to the type of control of the agencies.

As you can see, most agencies are freestanding and many of them are in an urban setting. Many agencies are proprietary in this sector but not a majority. A small but significant number are operated by state, city, or county health agencies.

As part of our work on volume, what we can do is break the episode volume down into these categories if you'd like to see data on that kind of breakdown.

We have two questions regarding access to care for beneficiaries. First, are there providers in beneficiaries' communities, and can beneficiaries access those providers. This map is an indicator of the answer to the first question. It indicates that 99 percent of Medicare beneficiaries lived in an area that was served by a home health agency in the past 12 months as of May, 2003.

This suggests that access for beneficiaries, in terms of whether there is a provider in their community, is very good. Some of the largest white areas on the map, indicating there were zero home health agencies, include deserts, swamps, and timberland.

The map is based on the zip code area of the beneficiary residents. In most cases, zip codes allow us to look at a sub-county level, although in some cases there are zip codes that will encompass more than one county.

The data is based on the zip codes as reported by the nurses or the therapist in the field as part of their patient assessment. Some providers have identified some discrepancies in the data as such as field reported. The database administrator at CMS has listened to these providers and received this data and eliminated where possible obvious discrepancies such as a provider in Florida who cared for a beneficiary in Nebraska.

This map may tend to understate the areas of service because it can only reflect where an agency actually delivered service. So if there was an area that it would be willing to serve but did not have a request to do so in the past 12 months, then it wouldn't show up as a service area for that agency on this map.

On the other hand, it may tend to overstate the service area of an agency because if an agency is only willing to serve a quarter or a portion of a zip code, then this map would reflect the entire zip code area as having been served. But that's a limitation of any time we try to describe service areas with a geographic unit.

MR. HACKBARTH: Sharon, on the first point that there simply was not a request for service, you may be able to deal with that a little bit by looking at multiple years? Is that possible? Are these data available for more than one year?

MS. CHENG: This is the first year we have this zip code level data. We could look at county level data and we could then use multiple years. One of the features that they're trying to maintain this database is to make it current so it actually rolls. So the 12-month period will roll forward, so it actually will contract that a little bit rather than expand it, as this database is developed.

In addition to most beneficiaries having access to one home health agency, as the map showed, we also found that most beneficiaries have a choice of providers. 97 percent of beneficiaries lived in an area served by two or more home health agencies.

Our second access question is whether beneficiaries can obtain care from the providers in their community. Our indicator for this is the most recent CAHPS surveys of beneficiaries. The proportion of beneficiaries who sought some home care and reported little or no problem with home health is about the same as the proportion who report they usually or always can make an appointment for routine care with a doctor or nurse, about 90 percent.

Of those who said they had a big problem, we do believe it appears that the problem was not an inability to obtain care because it seems that almost all beneficiaries who sought home care did receive it. We know that 7.5 percent of the beneficiaries used home care in 2000 and this is very close to the number of beneficiaries who sought home care in that year. According to the CAHPS surveys, 7.7 percent of beneficiaries sought some care, and we don't know how many of those beneficiaries were eligible for the benefit.

Our next indicator is entry and exit of agencies. In 2003 the number of agencies showed a very slight uptick. This year there will be about 7,100 agencies certified to serve Medicare beneficiaries. Along with evidence that mergers and acquisitions have picked up pace, this suggests that there are more and possibly larger agencies in the program than there were at the beginning of the prospective payment system. The composition of the agencies certified, as described earlier, has remained essentially the same for the past four years.

This time series shows how the number of agencies has

changed over the past 10 years. Today's number is about the same as it was in the early '90s before the pace of entries became quite rapid.

The final indicator I'll discusses this morning is access to capital. Access to capital is not a strong indicator for the home health sector. Access is determined more by the size of the industry and perceptions of risk than seems to be determined by the adequacy of Medicare's payments for this sector. The sector is small and the players in it are small compared to many that seek investors' dollars. Total expenditures in 2001 for home care services was $33 billion, compared to $450 billion for hospital care or even $100 billion for nursing homes. The largest publicly traded home care company has only a 2 or 3 percent market share.

That said, Wall Street has a positive outlook for the industry, predicting that will outperform the S&P 500 over the near-term. However, the publicly traded agencies have moderate ratings despite good margins and growth potential, usually due to perceived high risks for the sector from legal challenges such as subpoenas or legislative uncertainty related to the copay or a reduced updated in legislation. Medicare is noted in several of these industry reports as being the higher payer margin payer in the industry.

My final slide is a starting point for the national quality score we plan to bring you in the next presentation. The trend you see here is based on the scores for several activities of daily living and instrumental activities of daily living from a proprietary database of about 2.5 billion patient records. The score captures the average improvement or stabilization in a patient's functioning on each of these activities. Thus, if a hypothetical patient were to improve her ability to get around, stabilize her ability to dress her lower body while her ability to dress her upper body became more difficult, the score would be one. This is the average of two points given for the improvement, one point for the stabilization, and zero points awarded for the lack of improvement on the third ability.

Since this score is an average of all of the patients in the database, and the goal of care for many patients is the stabilization and their ability to perform these tasks, we would expect the scores to cluster around one, which they do this chart.

MedPAC staff is working with the creators of this score and we plan to do a couple of different extensions. First, we're going to extend this trend back into time and look at 1999. That's before the implementation of the PPS. We're also going to take it forward to 2002, so that we have a year of PPS experience. We'll also expand the database from the proprietary database that this trend is drawn from to a national OASIS database. We will also review the outcomes that you see in this chart and we will make sure that the ones that we choose are policy relevant, clinically appropriate, and operationally sound.

With that, I'd like to take your questions on the data and especially your reactions to this score and any changes you'd like to see to it. Thanks.

DR. NELSON: Sharon, I think that's very important, but there's a dimension that hasn't been dealt with with with respect to the impact of payment policy on what the beneficiary can access in terms of home care. And that is the contraction of the menu of available services that agencies have adopted under financial pressures. Whereas they may have offered diabetes education, ventilator care, other labor-intensive services in the past, some of them have modified the services that they offer in order to maintain a positive bottom line.

What that results in obviously is an impact on the beneficiary that has to be taken into account in addition just to whether there is an agency available in their area and what their access to capital and so forth is.

MS. CHENG: I tried to nip at that a little bit in the paper to suggest that when we think about access there are really three dimensions. Is there a provider in your community? If there is, can you access that provider, can you get through their door -- or in this case can you get them through your door? And then the third would be once they're there, are you getting what you need? Do you have access to the services once they're through the door?

The access measures that I have here, I really to think we're looking at the answers to question one and question two. And I guess what I'd like to do is run down the third question by looking at outcome scores like this to say all right if they're getting what they need then hopefully we're going to see a good outcome for that care. So let's look at changes in the outcomes. We're certainly going to have to adjust it for the severity of the patient because we think that the product is changing. But let's make sure that they've got a good outcome when they're gone.

DR. NELSON: But there may be a dimension of that in terms of what's desirable and not being provided, socially desirable, desirable from the standpoint of well-rounded care or whatever. When I'm suggesting is that it maybe that the trade associations or others can give you some information on services that formerly were provided when times were better and that no longer are being provided even though there may be a need or a perceived need for those services.

And the substitute for some of those, such as ventilator care, may be nursing home care. That is there may be more expensive substitutes. And that needs to be taken into account with respect to our payment recommendations.

MR. HACKBARTH: Alan, have you seen some data on agencies reducing services or is this just your personal experience?

DR. NELSON: No, I've seen data but not across a broad universe. I've seen reports from an integrated system that has a home care presence. And whereas two years ago they were showing red ink, it's a well-run outfits so that they've made changes. The changes they've made have been to contract the menu of services that they offer in their home health product. And so now it again is in the black. But it's been at the expense of a reduced menu of services.

Now, how generalizable that is, I don't know. That's the reason why I raised this as a question. But it may very well be

that the trade associations have collected data on how the menu of offered services has changed.

MR. HACKBARTH: In some ways, this takes me back to our conversation yesterday about bundling of physician payment, in that if you're talking about a bundle and a prospective system that creates an incentive to reduce costs, even if an agency has a high margin and they think that this is a service that they can reduce without damaging their position in the market or reducing quality, they have the incentive to drop it anyhow even if they have a lot of money.

So it goes to the question of how important is it from a quality standpoint? And do we have quality measures refined enough to detect that sort of reduction in quality?

DR. NELSON: [Off microphone.] You may not be able to detect it in the short-term. That's my point. I mean, diabetes education is a case in point.

MR. FEEZOR: Alan asks exactly the question I was going to, and from my narrow geographic perspective, a similar observation and actually some -- as I look over the operation sheets of a couple of regional home health I have seen a significant contraction in the array of services. And I was just going to urge that we try to see if we can get any sort of measure on that.

MS. RAPHAEL: I think we have seen some site shifting because we see an increased in admissions to nursing homes, I believe, at the same time that admissions to home care were declining. So there may be some site substitution, although I don't think we know enough to reach that conclusion.

I was going to make two points. One is that I would like to see some of the data broken down by type of agency because home health care is a very heterogeneous field and you have very small agencies and large public companies. And Wall Street is focused on the large public companies.

I think it is important to look at the whole array of agencies and how their faring, because I think what Glenn was commenting on before it is an issue that home health care agencies face in tandem with nursing homes, although a larger share of home health care payments come from Medicare. That is, those agencies that tend to serve Medicaid patients or the uninsured tend to have very low total margins although their Medicare margins are good.

And their survival or their ability to provide the whole panoply of services is at risk as Medicare payments begin to decline. So I think we need to keep that in mind because that can ultimately affect access in some of these areas where you don't have too many agencies currently available.

DR. STOWERS: I think a thought too, needs to go a little bit into changes in the package that came from CMS. The no IV drugs at home and that kind of thing now.

I've got actually a family member with osteomyelitis following a knee replacement that is going to have to spend six to eight weeks in the hospital getting IV drugs.

MS. RAPHAEL: We're the only ones in New York City still providing infusion nursing. Everyone else has left the

marketplace. And we're doing it at a loss.

DR. STOWERS: So there's some other of those related access things, too, that might need to be looked at that are tremendously inefficient for the system.

MR. HACKBARTH: Is it on this point?

MS. DePARLE: Not on this point. I wanted to ask Carol her view of this quality measure and whether you think we're going in the right direction.

MS. RAPHAEL: Well, I am concerned about using this as sort of the benchmark for quality even though it's a large database. There are two areas where we're seeing some sort of patterns that I think are cause for concern. One is rehospitalization rates. Our rehospitalization rates have gone up and our emergency room visit rates have gone up. Now we may be aberrational, but I consider those very important indicators.

And also, this has to do with the refinement of OASIS. We just believe that OASIS, and understandably, is very geared to what's measurable and very task oriented. And it doesn't pick up a lot of things that have to do with functional ability, cognitive impairments, that really can make a huge difference in whether you can rehabilitate and restore functioning.

So I just think there needs to be the next level of refinement of OASIS. I think it's done a very good job but we can't rest here and assume that it's really capturing all of the variables in terms of recovery and restoration of function.

DR. WAKEFIELD: Just a comment, Sharon, that I shared with you on the side the last time that we met. And that is I really like the use of the zip codes this time around because it gives us a sharper focus on one hand in some areas of the country than we had the last time we were looking at this data.

On the other hand, we lose some precision to the extent that zip codes, as you indicate here and so I'm really pleased to see that recognition, we lose some precision when zip codes cover larger areas than a county.

For example, when you go out west -- notwithstanding the fact Joe that yes, you do have Teddy Roosevelt State Park there on the western part of North Dakota, notwithstanding that -- some of our counties in the western part of the state are over 1,900 square miles. That's a pretty large area.

So if you've got a home health agency that's five miles over the border or 10 miles in or 15 miles in, just as an FYI, we lose the rest of the picture there. So you've got it identified but we do lose the rest of the picture.

And probably not a whole lot of folks out there maybe, but we don't know. And we don't know what proportion of folks that are out there are Medicare beneficiaries, for example, as opposed to 30-year-old ranchers, or whatever.

So it's just so important, I think, to have that -- I kind of like this western talk here.

So I think it's really important that we've got that caveat there because I look over here and I see 99 percent of beneficiaries covered and that's terrific. That's great, good news. And on the other hand, we don't really have the complete picture because we might just have parts of counties and even

less than a county almost, now that we're using zip codes, reflected.

And we do have the home health add-on that's expired now, that provided some protection for rural home health agencies. And so I think it is going to be important, all of these things coming together, to track on that what impact that might have, if any.

I think in one of our earlier reports, for example, and I don't know where it's at now, but we saw that there were longer lengths of stay in rural hospitals. And I think we thought in part that might be attributable -- we didn't know for sure -- but in part that might be attributable to a lack of availability of post-acute care.

So we're casting abroad our net, in some instances. We've got a congressionally legislated add-on that's expired. And we know that there was something going on, at least historically, with those longer lengths of stay but we don't know exactly what they were due to. So it's just making sure that this is reflected to be as tentative as it is.

And at some point in time, maybe we can go back and look at what's happening to lengths of stay to give us a measure. I don't know. Maybe we could look at a couple of counties and drill down in a case study sort of a way and see what is really happening there. But I just wanted to make sure that those issues are adequately reflected at some point.

Then the question I've got for you is, we've got 99 percent of beneficiaries covered and on our table one we've got a big problem for 12 percent for beneficiaries that sought access to home health care services. And that's statistically significant, a slight increase, but it is statistically significant. Do we know anything but that subset, that 12 percent? Do we have any characteristics of that population? It's small but the rise is statistically significant. Can we know anything about them?

MS. CHENG: I'd have to double check with Karen. This is the CAHPS data that we were talking about this morning, and I know we talked a little bit about how much you can slice and dice that. To the extent that we could, we'll give that a shot. I don't know what we'll be able to find out about that subset.

DR. WAKEFIELD: If you'd look, that would be great. Thank you.

DR. REISCHAUER: I wonder if we have spent too much time looking at institutions. This applies to the home health area, the SNF area. Do I really care whether the number of agencies has gone up or down? Or do I really care about where services are provided or available, and the number of services per unit of need over time?

I look at these things and you don't know if they're big or small, or are all the hospital-based SNFs 10 beds and all the other ones 50 beds? What's happening to the total volume of services? And should we be really looking at a chart that shows the fraction of Medicare beneficiaries who receive this kind of service over time? And is it rising or falling? And maybe you could adjust it for the changing age composition of the Medicare population.

But in a way, the number of institutions doesn't really make any a difference at all, I don't think, to what we're concerned about.

MR. HACKBARTH: And I think in the past we've noted that that's a particular problem with home health because the elasticity of the units. What I hear you saying is at some point the qualifications are so many that we ought to just stop doing them.

Others?

Okay, thank you, Sharon.