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 skilled nursing facility market factors
-- Susanne Seagrave

DR. SEAGRAVE: Hello. Today I will present some preliminary information on recent trends in SNF market factors. I'm going to cover these five market factors that we always look at.

First, I want to quickly address Bob's earlier comment, and just clarify something on this slide. When we look at SNFs entry and exit, we're looking at the entry and exit of Medicare certification only. We don't actually look at Medicaid-certified facilities. We look at Medicare only certified and Medicare/Medicaid. So we're looking at entry and exit into the Medicare program in this case.

With regard to SNFs entry and exit from the Medicare program, the 2003 data indicates that the trend that we've seen for the last few years continues. In the period 2002 to 2003, in the far right column of this slide, we see that the number of hospital-based SNFs participating in Medicare decreased by about 9 percent between 2002 and 2003. And the number of freestanding SNFs participating in Medicare increased by about 2 percent for an overall increase among all SNFs of about 1 percent. These percentages are essentially the same percentages that we saw for the period from 2001 to 2002.

In 2003, the number of hospital-based SNFs participating in Medicare is about the same as it was in 1993, I just wanted to point out. Part of the reason for that, even despite the rapid decline in these facilities in recent years, is as you can see the percent change in the number of these facilities from 1992 to 1998 was 61 percent.

I also just wanted to show you that there has been some entry of hospital-based SNFs into certain areas as well. The numbers in the far left column represent the number of hospital-based SNFs in 1997 in hospital service areas. The numbers across the top represent the number of hospital-based SNFs in those the same hospital service areas in 2001. As you can see, about 92 hospital service areas that didn't have a hospital-based SNF in 1997 did have one by 2001. So there has been some entry.

As well, when we look at the number of beds by freestanding and hospital-based in these areas in 1997 and 2001, we also find that freestanding SNF beds have perhaps substituted for some of the loss of hospital-based SNF beds. For example, in the 308 hospital service areas where there was one hospital-based SNF in 1997 and none left in 2001, the average number of freestanding SNF beds in those areas increased from 336 to 352.

Recall from the last meeting that a disproportionate number of hospital-based SNF withdrawals from the Medicare market since 1997 have occurred among for-profit SNFs operating in urban areas. In addition, this chart shows that per diem cost tended to be higher among hospital-based SNFs that exited the Medicare program. The reported aggregate per diem cost in the hospital-

based SNFs that left the Medicare program at $321 a day in 1998 were about 43 percent higher than those of the hospital-based SNFs that remained in the program.

Moving on to our second market factor, the volume of SNF services, we can see that the volume of SNF services increased in 2001, the most recent year for which we have data on this factor, with total payments to SNFs increasing by about 22 percent, total number of discharges increasing by 6 percent, covered days increasing by 8 percent, and average length of stay increasing by about 2 percent.

We are still collecting information on recent trends in beneficiaries access to SNF services for 2003. OIG studies in 1999 through 2001, and the focus group of hospital discharge planners we held in October 2002 you may remember, all suggested that beneficiaries needing rehabilitation services generally had no problem accessing SNF services, but that certain patients with complex non-rehabilitation therapy needs may have experienced delays and accessing these services. These patients may have stayed in the hospital longer in some cases, although it's uncertain whether this is a worse outcome for some of these patients.

I did want to mention the fact that we are still collecting information on this for 2003 and I hope to bring that to you in subsequent meetings. Also, the OIG now plans to do a study on access to SNF services, to be released sometime in fiscal year 2005. This is very good news for the future, although obviously it won't help in our analysis this year.

I wanted to bring you some preliminary information from our analysis of readmission rates on quality. As you can see, it doesn't look -- the measures that we have seen so far don't indicate big changes in the quality of care delivered in SNFs between 1999 and 2001.

I wanted to explain these five categories of SNF readmissions to the acute care hospital were analyzed by researchers at the University of Colorado Health Sciences Center and found to be the types of readmissions that were most preventable if SNFs were delivering quality of care to patients. We used the Colorado methodology and analyzed the SNF readmissions for these years ourselves and we found that if you adjust -- I wanted to point out too that these are all adjusted for the case-mix of patients and based on the national average rates across all SNF admissions for these years.

We see small increases in the rates of readmissions for two of the five conditions, electrolyte imbalance and congestive heart failure, but virtually no change in the other three measures.

Finally I want to briefly discuss our preliminary findings on access to capital. As you know, the nursing home sector is a fragmented industry with only about 16 percent of the beds accounted for by the top 10 largest chains. The nursing home industry is also dominated by for-profit companies, about two-thirds of nursing homes are owned by for-profit.

Access to capital for some has always been limited, particularly for small and nonprofit providers. In addition,

equity issuances have been a source of capital for the nursing home industry in the past but there were no issuances in 1999 through 2001.

Publicly traded bonds were a source of capital for this industry in the past and still are today but at lower levels. Furthermore, debt ratings have been downgraded, leading to higher interest rates charged to nursing homes for debt. Still, despite all of this, the stronger nursing home chains may still have continued access to capital.

Other sources of capital for this industry include bank loans, real estate investment trusts, and federally guaranteed loans of which about $1.2 billion in fiscal year 2002 were issued.

The bottom line for all of this is that the situation with SNFs' access to capital has worsened recently due in large part to reduced Medicaid nursing home payments. However, it was also due to the expiration of two temporary Medicare payment increases mandated by BBRA and BIPA and the increasing costs of liability insurance for nursing homes. Still, financial analysts continue to view Medicare SNF payments in a positive light. Fitch Ratings, for example, said in its recent analysis of the nursing home industry that it "views Medicare reimbursement favorably as Medicare is generally a profitable payer for most nursing homes."

I just wanted to mention that in the chapter and the next time, we will be discussing more about the proportion of Medicare that's accounted for in nursing home payments.

This concludes my presentation. I welcome any questions the Commission might have.

DR. MILLER: If I could just say one thing quickly, your point about the Medicaid, the expiration, and the increasing costs of liability insurance, this is what the financial analysts are saying are driving their conclusions on capital?

DR. SEAGRAVE: Yes, that's right.

MR. SMITH: It might be useful to note, or at least ask the question, of whether or not the huge increase in SNFs between 1992 and 2003 has something to do with the decline in activity in the capital market in the past year. This is an industry which one might conclude had expanded too rapidly, there was overcapacity, and the capital market is reacting to that, or that and the changes in the payment system.

DR. ROWE: I have a general question but one small point first. Most studies, I think, of the admission rates showed that, in addition to congestive heart failure, hip fracture is a diagnosis that has a traditionally very high readmission rate. Did that come up? I noticed that wasn't on your list.

DR. SEAGRAVE: Yes, the researchers in the University of Colorado very carefully chose these five admission rates.

DR. ROWE: These weren't necessarily the five highest?

DR. SEAGRAVE: No, they were chosen specifically because these were deemed if a nursing home could implement processes or perform their care and monitor the patients in such a way that they would have a pretty good chance of keeping these people out of the hospital for these five conditions.

DR. ROWE: Thank you, Susanne.

The question I had has to do with how do we approach a situation where the Medicare margin is positive or favorable, the overall institutions aren't doing well for other reasons, you know, Medicaid payments are down, access to capital is down, their ratings are down, their interest rates are up, whatever is going on, but if they go away, then access to their services is diminished for Medicare beneficiaries?

We don't want to go down a pathway of just paying more and more and more to keep them alive. On the other hand, there is the other hand. It seems to me it would be interesting, I know we dealt with this before, but here's a stark example. If you start with Bob's suggestion at the beginning of the chapter about how important are these, yes or no, it's going to be small proportion of their budget but it's going to be a big proportion of their margin if they have any, right?

MR. HACKBARTH: I think, Jack, you're actually restating a point that Dave made last year when we talked about the SNF update, expressing very similar concerns about access. The problem that we face is that given Medicare's low share of the total revenue base of SNFs, about 10 percent as I recall, is that right Susanne, 12 percent?

DR. SEAGRAVE: 12 percent, yes.

MR. HACKBARTH: That's a very small base on which to rest the financial stability of a whole industry. But even more problematic than that from my perspective is that the tool that we have at our disposal is to increase Medicare payment rates. And it doesn't get the money to the right places. So the most money would go to the SNFs that have the largest Medicare patient loads and the lowest Medicaid patient loads, and have the highest margins.

And so it is a very --

DR. ROWE: [Off microphone.] If you're talking about access, that's most -- --

MR. HACKBARTH: So it's a very poor tool to deal with what is perhaps a Medicaid problem principally. I'm sort of old-fashioned. I think if you have a Medicaid problem you ought to fix it in Medicaid as opposed to try to fix it with Medicare add-ons.

DR. ROWE: If you have a Medicaid problem, from the point of view of the budget of the institution. But we're here to serve and protect the Medicare beneficiaries.

MR. HACKBARTH: We're here also to --

DR. ROWE: So I'm a Medicare beneficiary and I can't get in a SNF and I call you. Are you going to say well, call the governor?

MR. HACKBARTH: We're also here to advise the Congress, that's our principal purpose, on what is the best policy for dealing with problems facing the Medicare population. And I don't think the best policy is to try to balance the books of a whole industry through Medicare updates.

MS. RAPHAEL: I was just going to say, this is certainly a very, very important issue. But 19 states actually cut the Medicaid rates that they pay to nursing homes in this last fiscal year. So there's clearly great stress in the Medicaid system

that finances nursing homes in this nation.

MR. HACKBARTH: And I wonder what would happen if Medicare says we'll assume responsibility for the welfare of the industry. If you're a governor facing a deficit, that seems like an invitation to further cut.

MR. DURENBERGER: The point would probably not -- and I did not know it when I raised it and you re-raised it, the point in not is the Medicare program the answer? The point is are members of Congress an important part of the answer to the problem of adequate access?

It's more in how we deal with this issue in the advice that we give people where we see capacities strained or capacity declining that we can make a contribution with the kind of information that we've developed as it relates to all of these factors that she has laid out here.

I mean, I agree with you that it is difficult if not impossible to use Medicare policy directly to accomplish it. But I think the members of Congress need to understand it isn't 19 governors or 19 legislatures alone who create problems in the decline in Medicaid revenues going to subacute or to nursing homes and so forth. It is a combination responsibility of policymakers at a national and a state level.

MR. HACKBARTH: Just one additional point. In the one area where we did have some reason to be immediately or more immediately concerned about access to care for Medicare beneficiaries is in the more complex patients. And in that instance we made a specific recommendation how to deal that particular problem, mainly reallocating the add-on dollars.

Now in fact, it wasn't accepted, but where there is a problem we tried to make a specific concrete recommendation.

DR. REISCHAUER: I basically agree with you, Glenn, on this issue but it is a bit more complicated because, of course, many people enter the nursing home as a Medicare patient and the benefit is of limited duration or their private sources decline and then become a Medicaid person in terms of being paid for. But they are still a Medicare person when they go to the hospital or have a doctors visit or anything else as the primary payer. So it is a little bit more complex. If they don't have the care through Medicaid in the nursing home Medicare's spending on acute care services might rise.

MR. HACKBARTH: Others on this issue?

Okay, thank you.