MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 4, 2003
10:13 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
NANCY-ANN DePARLE
DAVID F. DURENBERGER
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: During my time with you I'd like to do four things. I'm going to take just a moment to review some of the information that we've already had concerning payment adequacy. I'm going to introduce some new information on beneficiary access to care, the volume of home health services, the quality of services, and the margins. Then I'll consider changes over the coming year. And finally, we'll have your discussion of the draft recommendation.

To review briefly, the conference report reduces the marketbasket update by 0.8 and restarts the rural add-on at 5 percent. Both changes will occur halfway through fiscal year 2004. In October we discussed some evidence that access for most beneficiaries to this benefit is good. Geographic access includes 99 percent of the beneficiaries. Ninety percent of the beneficiaries surveyed reported little or no problem in obtaining care.

We've also seen that the supply of agencies in terms of the number of Medicare-certified home health agencies has risen slightly since the implementation of the PPS. Good access and a rising supply of agencies both indicate that payment is at least adequate.

Because of continuing concern about access to care we have pursued this question further with two additional studies. In June we contracted with Chris Hogan of Direct Research to look at claims data and demographic information of the Medicare beneficiaries. We found that during the period of decline in home health from 1996 to 2001 the greatest declines occurred among users with the least well-defined needs for skilled care. That is, when we compared the diagnoses of users before and after the decline we found that users with markers of frailty and chronic conditions such as COPD or chronic heart failure had the greatest decline while those who could conceivably be restored or recover under home health care, such as strokes or hip injuries had smaller declines.

This change is consistent with the change in the focus of the benefit from the continuing care of chronic conditions to the recovery from illness or injury. We also found that users in the highest use states had greater declines.

In a separate study, Nancy Ray used a national survey of home health providers about the demographic and clinical

characteristics of their patients. We found that the older-old and the more functionally disabled used the benefit in greater proportions in 2000 than they did in 1996. Use by female beneficiaries as a proportion remained about the same.

In both of these studies there is no evidence that these vulnerable populations have been systematically excluded from this benefit over this period.

In the recent past volume has been particularly volatile in this benefit. Some of these changes in volume reflect differences in the volume of users, which rose from '92 to '96 and then fell during the IPS and the initial year of the current payment system. Other changes in volume reflect changes in the product that is home health, the number of visits per episode, the mix of visits by visit type, the typical length of stay for a beneficiary from the time that they were admitted to home health to the time they are discharged from home health.

In 2002 and the first half of 2003, rapid reductions in the number of visits per episode and the length of stay have slowed. Perhaps the current average of 18 visits per episode, which showed almost no decline over 2002 and the first half of 2003, will continue. The length of stay in home health actually ticked upwards slightly between 2001 and 2002. That's another sign that the trend of shorter episodes with fewer visits may be ending.

The changes in the mix of visits have also continued, but at a much slower pace as we've seen therapy continue to become a slightly larger proportion of the total number of visits in terms of the mix of visit types. If payments were not adequate we would expect the decline in volume to continue. That would be consistent with the product change and the incentives of the PPS which is a capitated system. However, the steadying of these volumes suggests that payments perhaps are adequate.

To pursue this a little further, we analyzed a 5 percent sample of claims to count the number of unique beneficiaries annually using this benefit. The volume of users has fallen in the past according to the CMS trend that I've shown on the left hand here. From our analysis on the right hand, the number of users appears to have increased between 2001 and 2002. We will continue to monitor the volume of users. Based on the change from 2001 to 2002, the evidence suggests that payments are at least adequate to incent providers to take on some new beneficiaries.

Another piece of new information that we have regarding the adequacy of current payments is a measure of the quality of outcomes of care. This graph displays be pre- and post-PPS measure of quality for home health. This score was developed for MedPAC by Outcome Concept Systems. It summarizes clinical

and functional improvements as well as adverse events for all the beneficiaries in the national OASIS database. We use the scores on the OASIS patient assessment at admission and then we compared them to the scores at discharge. Patients received a two for improvement, a one for stabilization, and a negative one for a decline, or for one of four sentinel or adverse events that occurred during their stay in home health.

As you can see, the median score from 1999 to 2002 is virtually the same. Now this is based on 100 percent of the OASIS assessment so it is a real difference, but you can see that the difference is smaller than the standard variation in 2002.

Since the quality has remained the same, that adds an important context to two important indicators in our framework. We can see that beneficiaries have had the same access to the services that they need before and after the PPS because their outcomes have not declined. Also since quality has remained the same we can conclude that the decline in the cost per episode is a real increase in productivity rather than substituting an inferior product. We also looked at the severity of patients and we can also conclude that it's not a substitution of less severe patients for more severe patients because the severity of patients at the beginning of their care in these two years rose from 1999 to 2002.

The final new piece of new information that we have on payment adequacy are the margins. One of the issues that we had last year was a somewhat smaller sample of cost reports than we would have liked. This year we have some real improvements in our cost report data. I want to genuinely thank the folks at CMS who not only processed all these cost reports in a very timely manner at the same time that they were making a tricky transition from one type of database to another. We appreciate the efforts that they made to make this data available. As a result of their hard work we now have 3,500 cost reports, and that's substantially all of the annual cost reports for freestanding agencies with Medicare costs and payments greater than zero.

This year we were able to use a full fiscal year sample of cost reports. They did not span the implementation of the PPS, and thus we've avoided a cost allocation problem. The cost reports that spanned the implementation date appear to have underreported their costs under the PPS compared to our newer, complete sample. This cost allocation did affect our sample last year but it will not have an impact on our future samples of cost reports. Because our latest data is also newer than it was last year, we were able to use a large sample of fiscal 2002 cost reports to measure the trends in cost between 2001 and

2002.

So using this new sample we have derived our estimate and projections of the Medicare freestanding home health agency margins. The aggregate projection for 2004 is 16.8. This number does reflect the provisions of the conference agreement.

We also had an opportunity to look at the margins by type of control of the agency. You see that voluntary, for-profit agencies had a lower margin than the private agencies, and government had a somewhat lower margin than that. We also compared the margins of urban and rural agencies and this is by the location of the agency. The 2001 estimate includes the rural add-on that was in place at that time that was 10 percent for the entire year. The 2004 projected estimate includes an add-on of 5 percent that's in place for half a year.

As you can see, in 2004 the urban and rural margins moved somewhat closer together, and the rural is somewhat lower than the urban. However, we also looked at this in terms of the caseload of the agency and when you compare agencies with 100 percent urban caseload to agencies with 100 percent rural caseload, the rural caseload agencies are slightly higher again than the urban; the same relationship that they had in 2001.

In summary of this table, the aggregate margin of 17 percent would appear to be more than adequate payments for the Medicare costs.

Now I'll move to changes that we expect over the coming year. The marketbasket which measures changes in input prices is 3.1. However, evidence suggests for this sector that productivity and product change will offset the increase in prices. We base that on our observation that cost per episode fell 10 percent from 1999 to 2001 and they continued to fall between 2001 and 2002. We have estimated for the purposes of our model that they will not rise over the coming year.

We also have evidence that scientific and technological advances will continue to proliferate. Some agencies have only made these investments and given their potential it seems likely that they will continue to diffuse throughout the sector.

The two most important scientific and technological advances that we have seen for this sector is the increased use of electronics in the home, such as bedside monitoring and diagnostics, and the use of negative pressure or hot wound therapy. Both of these therapies have evidence that show that they can enhance quality in studies from journals such as the Annals of Vascular Surgery and the Journal of Dermatology. It is also found that better monitoring can catch problems like weight change faster which should improve the outcomes for beneficiaries.

These technologies can increase prices in the long term,

but those same studies generally found that they would improve productivity because they can decrease the number of visits necessary per episode to treat a wound or to monitor a patient.

In our framework, evidence of upcoming scientific and technological advances could lead us to recommend an update that's slightly larger than otherwise. We do find that this sector has limited access to capital, but we also note that they've had several years of large, positive margins which ostensibly could have been used to make the advances in these scientific and technological advances.

Which brings us to the draft recommendation. Taking into account evidence that current payments are at least adequate or more than adequate, as well as evidence that payments will continue to be adequate over the coming year the following draft recommendation has been developed. That Congress should eliminate the update to payment rates for home health services for fiscal year 2005.

The spending implication would be to reduce spending compared to current law, and given our evidence we conclude that the beneficiary and provider implications would have no major implications for this sector.

At this time I'd like to get your discussion of the draft recommendation.

MR. HACKBARTH: I know Carol has a comment but could I just ask a question, Sharon, about the preceding slide? The second bullet says productivity and product change will offset the increase in prices. Earlier you had made the point that one of the forms that much of the product change took early on was the reduced number of visits per episode. If I understood you correctly, that has leveled off now, so that aspect of product change may have run its course.

But you're still saying that notwithstanding the fact that fact that the visits per episode is flat that you think the productivity and product change will offset the increase in input prices? Am I understanding you correctly?

MS. CHENG: The change in the model that I made between this year and last year was that last year I used the evidence that I had that the product was changing and that costs were going down to actually project that costs would continue to go down. This year I see that the costs did go down between '01 and '02, and I don't see evidence that the product change is going the opposite direction so I've modeled that they will not increase but I have not modeled that they will continue to decrease. So I actually have a cost change of zero.

MR. HACKBARTH: I'm not sure I follow.

DR. MILLER: For just one second let me try and clarify this. I'll take responsibility for this. We talked about what

words to put in here. I think the point -- and make sure I get this right, Sharon -- is that we continue to observe a reduction in cost per episode. We didn't find the drop in the visits like we had previously so we weren't quite sure to attribute what this reduction in cost was to. So we were, what should we be saying here, and I think I said, just put productivity and product change since we don't know what was really driving the reduction in the cost. But we did continue to see -- I hope I'm getting all this right -- a drop in cost. We just didn't see the drop in visits like we had in previous years.

Then her last comment is, in order to be conservative we didn't assume that their costs declined in forecasting forward, we just assumed that they would be flat. Is that fair, Sharon?

MS. CHENG: Yes.

MS. RAPHAEL: I just want to enlarge the payment issue here and take it a little beyond just the question of the payment update, because this is two years now since we've introduce the prospective payment system for this sector and I think we've seen effects on reductions in utilization. We've seen effects on the types of patients who are receiving the benefit. We've seen, I believe, very serious changes in payer mix. We've seen changes, I think, shift of site of care and effects on out-of-pocket costs for beneficiaries. Lastly, I think we've seen some effects on access.

First of all, I think that one of the areas that I'm very concerned about is if I see that it is advantageous to change your payer mix so that you have a higher Medicare percentage, pure Medicare percentage. Because for example, an organization like mine that has one-third of our patients who dually eligible, that group of patients in fact have much lower margins than those that are only Medicare beneficiaries. In fact the irony of it is that that group of patients have a lower case mix index. You can say, how can that be? And they use more services.

So the way that the OASIS and the whole categorization and scoring occurs is that you don't really get a different score for being somewhat dependent or totally dependent, and it's not a good predictor of the use of paraprofessional services. So my average Medicare-only patient they have nine home health aide visits. For dually eligible they 23 home health aide visits, even though that category has a lower case mix index. So that that group is a much higher utilizing group. Whether it's because they are poorer, more likely to be disabled, less likely to have caregivers, I don't know all the reasons. I certainly have no clear information, I just have my own experience to draw from here.

But one of the concerns that I have is that I think -- and

I just was speaking to one of the Wall Street analysts who had called me and he told that one of the companies in the last quarter had increased their Medicare share by 11 percent in one quarter. So that you can have a gravitation toward taking only Medicare beneficiaries and you can really impair organizations that take dually eligibles, because it is much less advantageous to take that segment of the Medicare population. I think that we have to really look at the implications of payment on access and future access for that particular group.

In addition to which, I just continue, and Sharon knows I feel this way, not to agree with the conclusion that the focus of this benefit has changed, and that it what Congress intended. That we focus on people who have had hip fractures and that we don't focus on people who have cardiac conditions, congestive heart failure or pulmonary disease. The norm for people over 80 is they have chronic conditions with acute exacerbations. It's not just the norm that they have an acute injury or an acute illness. The norm is quite the contrary. This benefit should be for people who have chronic conditions with acute exacerbations. I don't think that we're looking to change that.

When we say that we comfort ourselves that the decline has been for those who have a less clear and defined need for home health care, that is those who have pulmonary disease and congestive heart failure, I don't take great comfort in that because that's a group as much in need as the group that's had a fall. So I'm very concerned about drawing that sweeping conclusion which we draw.

We look at utilization in 2002 and we also draw comfort, all is well with the world, because the same number of people are utilizing the benefit in 2002 as did in 1992. But guess what, I think there were 37 million Medicare beneficiaries in 1992 and now there are 40 million and the proportion of those over 85 has increased. So I don't draw great comfort from that either. So I really think we need to spend some time taking a look at these issues.

Now I know you quote this one study, the National Home Care and Hospice Organization study, but I believe that the National Institutes of Health Statistics suspended that study because they thought that it wasn't a good survey and they're really trying to recast that study. If you look at the Health Affairs article in September and October by McCall and Murtaugh, they say that basically the probability of getting home health care for the 85 and over has in fact declined between '99 and 2001.

So I think there are some very important issues there that we need to pay attention to. I'm not even talking about uncompensated care, because I, for example, this year have seen 8,000 cases that have no insurance. And I don't get any DSH

payment for seeing uncompensated care cases in the current system. So I'm not even raising that because I know DSH has another set of issues attendant to it.

But I do think we have to ask ourselves what kind of agencies do we want to ensure are there in the future so that we have broad access for all parts of the population here, and that we don't have incentives in the system that lead you to go only in one direction.

In the June report we had made a statement that we thought there was some shift of site of care to nursing homes and some substitution for home health care. We also have had a principle that we really believe that any substitution should be on clinical grounds not on payment grounds. I think we need to go back and look at that, because I don't know why that substitution is happening and why nursing homes have grown in terms of the number of patients and home health care as a sector has declined. So I just think that's another important area.

I have issues around productivity but it's probably not too much different from my other colleagues who have expressed it, but I know we're like a tertiary care center in home care. You talk about the vacuum pressure and heat in wounds. Less than 3 percent of our wound care patients are getting that, and we have the most broadly disseminated technology. You can use it for surgical wounds, you can't use it for vascular wounds. You have to have a caregiver to do the dressings.

Sharon, you attended this big colloquium we had of all the agencies who are involved in a big quality initiative, and it's infinitesimal how many of them actually have computerized. It's an aspiration. It's not an actuality.

So I just think that I don't see this productivity gain that we're purporting here. I see it in the literature. I don't see it yet in practice.

DR. WAKEFIELD: A couple of comments -- and actually I think you touched on it, Carol. I was wondering about where -- and maybe we did address this somehow in the June report because you seem to allude to it -- where the users with least well-defined needs are described, those with chronic care problems, CHF, et cetera, where then now are they getting their care? Are they getting their care? Do we have any sense of that? If the benefit has shifted in terms of what's being covered then what's happening to that patient population in terms of that particular care need?

I'd only say just as an anecdote, there was an article that appeared in our local newspaper just within the last week about a Medicare beneficiary who was being seen at home for congestive heart and they were using a phone and access long distance using telemedicine technology, and the numbers of hospitalizations of

that particular beneficiary -- now that's an anecdote of one -- but it had dropped significantly as that patient was being followed at home, and in fact long distance at home than the previous year. So it was touting the benefits of telemedicine, but also the point being made that that was a patient that was not using inpatient services to the extent that he had in the previous year.

So I'm wondering about that. Where are those patients, those Medicare beneficiaries getting their services and how are those being paid for? Just as a question. Perhaps you can't answer it.

Then secondly, we've got a chart that talks about Medicare freestanding home health agency margins but I don't know what's happening with hospital-based home health agencies. I don't know what the distribution of hospital-based home health agencies rural versus urban. I don't know what they are but my guess is that we tend to see a fair amount of them in rural areas -- at least that's what I hear from my rural hospitals -- that when they don't have anything else they've got to -- in order to ensure that there's some provider of home health agencies it falls to the hospital as the last person or entity standing in the community to provide that service.

So could you give us a breakdown of what might be happening with hospital versus freestanding on home health, just as we've seen that with SNF, for example, the hospital versus freestanding SNFs? I guess that was probably my second and last point, because it looks like our recommendation applies to all home health services in both of those categories but I'm only seeing margin data on one.

MS. CHENG: That was a decision that we actually made in looking at the cost reports. We do find that the freestanding home health agencies were 68 percent of all agencies in the program, 70 percent of all Medicare payments, and 67 percent of all episodes. So they are the majority of the providers in the program.

When we looked at the distribution we didn't see substantial differences in the distribution of freestanding and hospital. I can give you more detailed breakdowns on exactly how they pair up. But we felt that the cost allocation issues that are common to all of the hospital-based units seemed especially to hit home health agencies that are hospital-based. So we felt like the biggest difference between hospital-based and freestanding was the cost allocation that the hospitals made more than a real difference in their performance. So is not quite apples to oranges which is why we don't lump them together.

DR. WAKEFIELD: We always add the wraparound language about

cost shifting within hospitals. But if you're talking about the similarities with this, to say inpatient versus outpatient margins, if that's you're saying, but we also have at least historically always looked at those and then inserted that caveat. Are you saying these numbers would be so murky and so misleading that it's not worth even taking a look at what those margins are for the inpatient --

DR. MILLER: I think the answer to that is that we're going to move into the hospital section next, but at this point we don't have -- we'll have for the January meeting hopefully, we have an aggregate margin for the hospitals. We're not going to be able at this point to detail the allocation within hospitals and even break down hospital types at this point. We just aren't that far in the analysis. You're point is taken but we're not going to be able to present it at this meeting.

DR. REISCHAUER: Just on that point, do we have any information about the closing of hospital-based home health agencies? Because if they're growing or they aren't shrinking, then one might conclude that it's not a bad line of business to be in.

MS. CHENG: There's a table in your materials on page 7 that gives you a breakdown of the agencies by type. In '98, freestanding were 72 percent of the agencies, facility-based were 28 percent. And if you read that across it's 70/30 and then it/s 72/28 again in 2002. So as a proportion of the sector it stayed essentially the same.

MS. BURKE: I don't mean to be repetitive but I am as concerned as Mary about want this suggests about our capacity to evaluate the impact of a no update for the hospital-based facilities as compared to the freestandings. I also very much agree with Carol, I think there are a whole series of issues about home care. I agree with Carol, I don't think that we intended that the nature of the service change, or the nature of the patient that we serve change to the exclusion of people that we had cared for traditionally. Our capacity to care for people at home has clearly changed. Our capacity to introduce technology has allowed us to care for people that years ago when I was in practice we couldn't have cared for in a unit.

Having said that, I don't think it was to the exclusion of the chronic patient. I worry about a presumption that in fact, all things being equal, that there is no increase needed because of the margins we see that are based on the presumption that we're changing the nature of the patient.

I also am sensitive to Mark's point, which is that we can't easily examine the hospital and how a hospital allocates costs. But I think to suggest that in the absence of that information we presume that this kind of an update makes sense for hospital-

based units who may face very different kinds of circumstances is risky, and it concerns me. Yes, we have remained relatively stable but that occurred after a period of time where there was a shift away from hospital-based to freestanding. All the changes in terms of the way we financed home care that occurred in the '80s and '90s led to a dramatic increase in the number overall and a shift towards freestanding.

But I am very concerned that we look carefully at hospital-based as an individual set of institutions rather than presume that this answer is the right answer for that segment, because I don't think we really do know what the impact will be, nor the nature of that in terms of the kinds of patients that they serve.

DR. STOWERS: I just want to echo a little bit about what Carol was talking about. On page 6 you mentioned that we maybe needed to look into the fact that there was a decrease in home health aide visits, and then in the chart on page 10 we see that it dropped from 50 percent of the visits down to 23 percent of the visits. In our practice, I just want to try to describe what that's really interpreted to.

When we have chronically ill, 80-year-old patient that's had an acute episode of congestive heart failure and they become debilitated from it, it used to be that five to six days a week they got a bath, and someone came in and changed the sheets and took care of the home. Now in we're really lucky I can get someone into the house to do that twice a week since the PPS has come into effect. So that's the state of the health or cleanliness of that patient at this point because those aides, they're just not there any more. That's if we can get them at all. I would say half of our agencies don't have aides at all anymore. So that has fallen on the families, if they have a family to do that, and most family members are not either mentally or physically prepared to come into the home and do that kind of care and lifting and that sort of thing.

So when that structure breaks down, what's happening is they're going into the nursing home earlier, not because we don't have a great physical therapist or great nurses or that kind of thing, but they are diverting off because the patient is left in an unclean situation and an unhealthy situation with a poor diet, no one to cook their meals for them. This may only need to be done for a two or three or four-month period until they can get back on their feet out of this acute episode that's happened in their chronic medical illness because home health is now geared up for a post-fracture or post-hip surgery or whatever that we weren't geared up for in the mid-'90s.

So I really think we need to look further at this structure of care because we're concentrating on high skilled nursing care

and physical therapy and all that, but what keeps these people at home is often the lower-skilled individual that just give them the basic of everyday care that they need, which we had before. It's been a drastic change in the type of care of these patients in their homes since -- just in the last two or three years. It's something to see on a daily basis and their quality of life. So I just wanted to make that statement.

DR. REISCHAUER: I have a lot of sympathy for Carol's plight, but I don't see that it has much relevance to the update issue. What we seem to be saying is, there appear to be quite healthy margins in every component of this industry that we can ascertain now when we slice it and dice it by urban and rural, and voluntary and private, and so on. We don't have the hospital cut yet but maybe we'll have it in January. So in the aggregate there's enough money but the payment system within that aggregate is biased in favor of the high skill type of care and what we need to do is redress that imbalance, and there's plenty of money to do it.

MS. RAPHAEL: Plenty of money to do it? I don't think there's plenty of money to do it, because if you have a high proportion of Medicaid, which I didn't even raise for the reason of trying to be consistent here. But if you have a high proportion of Medicaid and you have a high proportion of dually eligible, either you're in a rural area, inner-city, wherever, there isn't plenty of money. There's only plenty of money if you change the mix of your patients, and I think that's more important than utilization per patient.

DR. REISCHAUER: I'm not talking about plenty of money within your agency. What I'm saying is within the system. So those agencies that are doing a whole lot of the high-end type of home care would receive less and it would be shifted to those of you who didn't. But a 16 percent margin strikes me enough to walk around the neighborhood with.

MR. HACKBARTH: The other side of that coin is that the update factor is a crude tool to deal with the problems that you're talking about because it would increase payments to agencies that have carved out a very healthy, profitable niche. Sort of the blunderbuss approach to fixing the problem. But if I understand your point correctly, this is a distributive question. This is a case mix question, are we fairly allocating the dollars we've got as opposed to is there enough money in the system in the aggregate?

MS. BURKE: I'm not sure it's just case mix, Glenn. I think that could well be. Bob's point is right, there's probably enough money in the system. There is an aspect of it that is case mix in terms of what the distribution of patients look like. But I do worry that is still doesn't really

answer, and perhaps we will be able to, the nature of the hospital issue and the freestanding issue, which is -- I don't know what that looks like. It may have the same kind of margins, but I don't know that, and I don't want to presume that one location is in fact the same as the other. In fact it may be a case mix issue, it may be a geographic issue, but I don't know that without seeing what the a hospitals look like.

MR. HACKBARTH: On the face of it I would have thought that the allocation issues between inpatient hospital and home health may be somewhat less difficult than a service like hospital-based SNF, because you're talking about a business that is direct labor costs. They're operating, by definition, outside the hospital, not sharing facilities and the like, so the allocation, the accounting issues presumably would be less than for some other services.

MR. MULLER: If I can just, based on the discussion we're having here about whether with the perspective payment now we have some incentives, whether it's Ray's anecdote of the frequency of visits and so forth that causes people to flip back into institutional settings. Maybe you can refresh our memory as to the average cost of home care per year and do some sensitivity analysis of if X percent of these patients flip back into an institutional setting, whether it's hospital or a nursing home and so forth, what does that cost us in terms of the institutional costs versus what we're saving in the home care.

I think just having some kind of sensitivity chart in there, for example, let's say if a hospitalization is five times as much per year as a home care visit, then -- as Glenn said earlier, you shouldn't do your arithmetic in public too many times -- but basically if it costs you five times as much when they flip, then if 20 percent of the patients, to use that loose term, flip over from home care into an institutional setting, what kind of savings are we securing in terms of the program? Just do that kind of comparison, that would help.

I think, to go to Sheila's point briefly and Carol's as well, we've said a number of times and I raised the point earlier around physician payments, we try to just look at the margins inside the Medicare program and not look elsewhere. But obviously if you have a lot of Medicaid then in fact, like in Carol's caseload and perhaps some of the rural caseloads, you have less margin to be able to do the kind of things, to have the kind of amplification of services that when you run a more -- when you run a home care program that's largely Medicare that has these kind of margins. So what in fact may happen is you tend to skimp more because you're cross-subsidizing the Medicaid, and therefore that may have an effect on the Medicare

program if you're skimping on some of these services that cause people to get back into the institutional setting.

So again I fully understand why we don't want to get into saying we should use the Medicare program to cross-subsidize other programs, but if it has the effect of some skimping in the program because of cross-subsidy in Medicaid that then costs money to Medicare, if that isn't too long a sequence of argument, that's something I think we should be at least attentive to as to what the cost trade-offs are.

MR. HACKBARTH: Sharon, can we bring some data to bear on the issue of patients be readmitted to hospital or SNFs from home health? Some trend data, what is happening. That might be a metric worth tracking.

MS. BURKE: Glenn, could I just add to that? It would also be interesting, and I'm not sure whether we do know this, but what proportion of patients receiving home care are who are duals as compared to the general population. Is there a disproportionate number? Because that would also help us fully understand Carol's point, if in fact the number is greater than the number you find in the general population or against -- they tend to be high utilizers anyway. They tend to be more costly as a general matter. But I wonder if there's a disproportionate impact on home care. I don't know that there is but it would be interesting to know if there are any kind of data that tells us who it is that's using the service, which would give us some sense -- the case mix would pick up a little bit of that but not entirely.

DR. REISCHAUER: But the real question is, how has that changed over time?

MS. BURKE: True, absolutely.

DR. REISCHAUER: Which is what you want to know.

MR. SMITH: Building on Ralph's point, it would also be useful it seems to me, in going back to Carol a year ago, is what is the admission rate of the folks who are no longer receiving home care at all? That population, Sharon, that you described as the users with least well-defined needs, people with chronic multiple needs but who don't have something which fits more neatly into the way the PPS affects who ends up in home care in the first place. The problem may even be bigger, Ralph, than I think you were suggesting.

The other question, I think we have changed the benefit. We've changed it, in fact even if we didn't intend to, Sheila. Technology has changed the benefit a little but the PPS changed the benefit because it created a different set of incentives for providers. I do think the burden of a lot of this conversation is not whether or not Congress intended to do something stupid but whether or not Congress did something that has had a set of

consequences which we didn't intend. We've come back to this point in this conversation now for three years in a row. It seems to me, Mark, that it is useful to try to figure out how to get a handle on that.

The question -- it's not the precise way that we ought to frame it, but the question is, is there a benefit out there which used to be provided, maybe profligately and unwisely but in some cases usefully, which is not now being provided? And what are the consequences of that? What are the health care consequences? What are the admission consequences? What are the bounce back consequences to the Medicare program? All of those questions lurk in the background of this discussion and we've never made any real progress at getting at them. I'd like to see if we could try somewhat systematically.

MS. DePARLE: In response to your question, I think I remember that the Inspector General at HHS and perhaps even the GAO looked at, or tried to look at the question of readmissions among people who had been in home health or were no longer able to access home health. This was part of the immediate response to the decline in the number of agencies in some parts of the country after the BBA and the interim payment system. I don't remember the results of that but I think there may be some data at least from that period.

But in response to David and to some of the other discussion we've had today, certainly I think the data that we've seen and that we looked at last year reflects a more significant decline than most people thought would occur in utilization of home health as a result of the policy changes that were implemented in the BBA. But I think we need to remember that there was in fact a concern that the benefit was being overutilized and wrongly utilized and a number of the policy changes that were made were designed to address that, and to make some changes in the beneficiaries who received the benefit. Some of that was the concern about the homebound requirement, and I don't think that's even yet been resolved.

But beyond that there was a concern about the policy that was implemented to require the physician to certify was partly designed to get at this view, and I think in some cases it was well-founded, that the agencies were going out to beneficiaries' homes and saying, would you like home care and then sending the order over to the doc and saying, sign this, the person wants it. Also the split between Part A and Part B, moving home care around, some of that was a gimmick to get it off the Part A trust fund.

There was, perhaps after the fact but at least there was a policy rationale as well that you were dividing it up between those beneficiaries who were using it after a hospitalization

and those who were the others. In either case, I think this requirement of the physicians -- and the clinicians here should answer this -- I think that had a dramatic impact on the number of beneficiaries and maybe even the type of beneficiaries who were getting it and the kind of care they got.

Now all of this may now seem shortsighted and not cost-effective and there may be people falling through the cracks that we think should be getting home care, but I think we need to remember that however ill thought out it now seems, at the time I think people thought it was well-intentioned.

MR. HACKBARTH: I think that the core issue here is the ill-defined nature of what we're trying to buy. I think there have been historically different points of view within the Congress about what the benefit should be and whether in fact we were trying to accomplish a change or not by implementing a new payment system. I think there's some fundamental disagreement that's never been sorted out.

But you take the combination of the new payment system with fairly strong incentives to economize with an ill-defined product and it's pretty predictable I think that you're going to get changes in the product, because the economic incentives will be so strong that they will overwhelm the underlying patterns. Whereas if you're dealing with an area of medicine where there are very clearly defined standards as to what you need to provide, the economic incentives may have a very different, much more limited impact.

So I think one of our core issues -- and we've made this observation as I recall, in past reports -- is that we've got a vague notion and not uniform consensus about what it is we're trying to buy here.

Then on top of that we have the issues that Bob and Carol alluded to. Once you accepted that we're going to have a PPS system, a prospective payment system, are we fairly allocating the dollars we've got for different types of patients and what are the consequences of failure to do so? Then finally, of course, we have our standard issue about the update factor, is enough money in the system?

So we're in a position where we're focusing on the update factor, which is in some ways the little tail on this great big dog. The policy question that that ultimately raises is to what extent are we going to help these problems that we've been cataloging by pumping more money into the system? I'll leave it at that. In some cases the money might get to providers who will do good things with it and begin to address some of the problems we've identified. But I think it's safe to say that a high percentage of the dollars will not go there and will go just to the bottom line of people who are providing a different

sort of product. I think that's the dilemma that we face.

We're not going to resolve the longer-term issues obviously in the next month, but I think we ought to use this report as an opportunity to again lay out that there's a lot more going on here that needs to be examined than just the update factor and the aggregate amount of money in the pool. I'll leave it at that.

DR. STOWERS: I just think we'd be remiss, even if we don't give an update, to go forward to Congress and not talk about the maldistribution of dollars within this pool. I know we did it before, but we have one set of beneficiaries which it's very lucrative to take care and another set of beneficiaries that it's very difficult to get care for. It just seems like to me that ought to be brought to their attention again that that needs to be addressed. For us just to say, things are great in the industry, there's no need for an update, I just would hate to send that message to Congress.

MR. HACKBARTH: Refresh my recollection, we certainly have anecdotal information about that. I don't know if we've got actual systematic data on which types of patients are getting poorly served or not getting adequate access.

MS. CHENG: I've tried to put together a little list here. I think realistically between now and January we could -- we do have the OASIS on hand with our contractor at OCS. We could ask them to look at 1999. They have 2000 and 2002. We could ask what kind of conditions were the patients admitted trying to improve in those years, in terms of has there been a change in the number of patients with wounds that needed care over that time? Was there a change in the number of patients who needed functional improvement that had some kind of functional limitation? We could get a trend of that over time to take a look at this question of how have the needs of the patients been changing.

We could use OASIS. I don't think we can really get at a good hospital readmit rate, but what we could do is look at ER use and unplanned hospitalizations during the episode. We could look at those three years and see if that trend has changed over time to get a sense of the ER and the hospital use of this population.

One of the things that I brought a couple of months ago was based on the CAHPS fee-for-service survey. We looked at the difference between the proportion of beneficiaries who indicated they sought some kind of home care and our estimate of the number of beneficiaries who got some kind of home health care. In 2000 we found that 7.7 percent of beneficiaries sought some kind of home health care and 7.5 percent did receive it. We could pull that trend forward, I think, with the data we've got

on hand to look in 2001 and 2002 to see if the difference between seekers and obtainers has changed.

MS. RAPHAEL: In your data here, in that survey you had 25 percent of the people had some problem or great problem in accessing care, and the 12 percent that had a significant -- you thought the 12 percent that had a large problem you thought was statistically significant actually. So you have one out of four that had some problem or a great problem, and I'd like to understand that better.

MS. CHENG: Okay.

MS. DePARLE: Also when you say sought home health care, 7.7 percent, does that mean they had a doctor's order to get home health care?

MS. CHENG: The question was worded, did you feel or did a physician advise you to seek home care over the past year.

DR. WAKEFIELD: If you can, is could you also take a look at whether or not you could give us some sense of the distribution of hospital-based home health agencies by urban versus rural? You said that you think that they're pretty much the same distribution.

MS. CHENG: Yes, that was another item on my list. I'll see what I can bring you back of the hospital-based margins. We haven't dealt directly with the caregiver issue. I don't think I can bring too much data to bear on the question. If you're interested in maybe a discussion of the caregiver and how that's accounted for or not accounted for in the PPS payment system I could bring that back as well.

DR. STOWERS: Could you give us the different like income or profit margin or whatever for different types of patients?

MS. CHENG: For different types of patients?

DR. STOWERS: Like rehab after a total hip that's gone home versus an acute episode of congestive heart failure, that gets physical therapy and all of the rehab, what that payment would be.

DR. MILLER: I think we want to be careful about saying whether we can do that. Even if we have the cost and payment ratios here it's a question of allocation. I think the answer to your question is we can look and see what we can do. I just don't know whether we're going to be able to tell you for this HHRG or whatever, this is the profit margin.

MS. CHENG: I was going to be more cautious than you're being. I'm not sure we could pull that off.

DR. REISCHAUER: I'd be very careful about promising anything definitive on hospital admission or readmission rates simply because you can't just look at the folks who have the home health care. What you want to look at is everybody with this condition and what difference home health makes. Then you

have to control for the people who don't have home health for that condition but have the functional equivalent of a family that is doing some of this themselves. As you know, it's horrendously complex and I don't want some of the other commissioners to get an expectation that you could actually come up with something here and interpret it in the right direction.

Carol was looking at Table 1 and thinking that the glass was half empty, and I was looking at it and thinking it was half full and was going to say that we have to be very delicate in how we describe the situation if the theme of the first few pages here which is that supply seems to be adequate. Things are okay. Those who want it seem on the most part to get it. We have to draw on Glenn's remarks which is the nebulous nature of this service. Many people maybe don't know what it is that they could benefit from, especially when you go from a change of the system like we had in 1996 to what we have now. The people are different, their expectations aren't to get all of this so they don't look for it and they aren't unhappy. But they could benefit maybe.

MR. HACKBARTH: Thank you, Sharon.