MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 5, 2003
9:05 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.
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

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

DR. SEAGRAVE: Last but not least, I will discuss payment adequacy and updating payments for the skilled nursing facility sector.

As you know, in our March report, we will make an update recommendation for SNF payment rates for fiscal year 2005. In this presentation, I will discuss the steps that we used to come up with our draft recommendations for the coming year in this sector.

As you know, current law calls for an annual update to SNF payment rates equal to the full market basket increase which is currently forecast for fiscal year 2005 at 2.8 percent. This number may, of course, change as the year progresses.

As we've discussed before, freestanding SNFs, those SNFs located in nursing homes, make up about 90 percent of all SNFs. For this reason, we focus much of our attention on the nursing home industry.

This graph identifies the sources of funding for the nursing home industry in 2001. As you can see, the largest funding source was Medicaid followed by beneficiary out-of-pocket spending and Medicare.

On the next four slides, I will briefly summarize market factor evidence we have for the SNF sector this year. Since you've seen most of this before, I will not going into much detail, but I'm happy to answer your questions.

Regarding beneficiary access to care, the evidence we have suggests that the majority of Medicare beneficiaries have no problem accessing SNF services but that certain types of patients with special needs, such as those who have diabetes, need ventilator support, are morbidly obese, or 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 but this finding may point to problems with the distribution of payments in the SNF payment system. I'll return to this point later.

Regarding supply, the overall supply of Medicare certified SNF facilities and SNF beds appears to have reasonably stable since the adoption of the SNF PPS. As you can see from this graph, the number of Medicare freestanding SNFs has grown pretty steadily since 1992. The number of hospital-based SNFs peaked in 1998 and has declined each year since then. From 2002 to 2003, the number of Medicare-certified freestanding SNFs grew by about 2 percent and the number of hospital-based SNFs declined

by 9 percent, with hospital-based SNFs returning to approximately the number seen in 1993.

Just a note about this slide, we do not include Medicaid-only SNFs in these numbers because they're not relevant to this discussion. However their members have been declining since 1998.

Analysis of the supply of SNF beds nationwide indicates a similar pattern with the average number of freestanding SNF beds increasing and the average number of hospital-based SNF beds decreasing. Not surprisingly we find evidence that freestanding SNF beds often substitute for hospital-based beds in areas where hospital-based SNFs closed. Overall, in terms of supply, we don't find declines in the availability of SNF beds for Medicare beneficiaries.

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

Regarding quality of care, the evidence is mixed. Studies focusing solely on Medicare beneficiaries tend to find no major changes in quality of care since the SNF PPS. However, a small group of recent studies have found declines in quality among mostly non-Medicare nursing home residents since the SNF PPS. But it is still unclear how these results translate to quality for Medicare beneficiaries.

Overall we find little evidence to suggest that SNF quality for Medicare beneficiaries has declined in recent years, but it will be important to continue monitoring this area.

Now turning to access to capital. The evidence on access to capital is similarly mixed. On the one hand, CMS's annual analysis of the nursing home industry suggests that access to capital has worsened since 2002, due in part to uncertainties surrounding Medicare and Medicaid payment rates.

On the other hand, nursing homes' Medicaid funding situation for this year at least does not appear to be as bad as analysts initially had predicted. Recent reports by both the Kaiser Commission and GAO suggest that Medicaid nursing home rates remained relatively stable in 2004. Both sources allude to possible changes down the road if states budget crises continue and worsen.

We also find evidence, by the way, that some for-profit SNF stock prices have risen substantially over the past year.

And finally, nursing home market analysts generally continue to view Medicare nursing home payments as favorable for the industry.

I want to pause here and be clear that I'm not suggesting that the evidence says that overall financial performance in the

nursing home industry is just fine, but that the evidence does suggest that Medicare payments are at least adequate in this sector. Of course, this leads to the question then that the Commission has been very clear on about whether Medicare should subsidize other payer sources.

In summary, overall the market factor evidence suggests that the majority of Medicare beneficiaries needing SNF services will continue to have access to quality care over the next year. We do remain concerned about the minority of patients who experience delays in accessing care.

Now we turn to some of the new information that you haven't seen before. These are preliminary information on freestanding SNFs' Medicare margins. I'm sorry we were not able to bring you margins for hospital-based SNFs today. We had some difficulty with the data. We will, of course, bring these to you in January.

The middle column represents the aggregate SNF margin for Medicare payments and costs from SNFs' 2001 cost reports. We have used a very conservative methodology in computing this margin. As you can see, we estimate the margin to be about 19 percent in 2001 for all freestanding SNFs. As in the past, we don't see big differences in margins between urban and rural facilities and, if anything, rural facilities tend to look a little better on most of the margin measures.

The far right column contains our projections for SNF Medicare margins for fiscal year 2004. These projections, I want to note, exclude two temporary payment add-ons that were in effect in 2001, but they include the 6.26 percent permanent increase to SNF payment rates that took effect in fiscal year 2004. By January, we will also have 2002 cost report data, which may change our projected numbers somewhat. We don't expect them to change significantly.

Just a couple of quick notes about the distribution of a freestanding margins. In 2001 about 88 percent of Medicare bed days were in freestanding SNFs with positive Medicare margins. As always, there are some variation among types of facilities. For example, we see slightly lower margins in very small facilities with between one and 20 beds, in government-owned facilities, and in very low Medicare share facilities.

Overall our margin analysis shows that Medicare payments generally exceed SNFs' costs of caring for Medicare beneficiaries.

The last step in forming our draft update recommendations is to consider anticipated cost changes for fiscal year 2005. The best predictor what might be expected to happen to SNF costs in 2005 is what has happened to costs up until now. A number of studies have shown that freestanding SNFs reduced their costs

after the SNF PPS, both by negotiating lower prices for contract therapy, substituting lower cost for higher cost labor, decreasing the overall number of therapy staff they employ, and by decreasing the number of minutes of therapy per week they provide.

I want to mention along the lines of cost changes, we are aware of one new quality enhancing, cost increasing technology in this sector, the so-called wound vac. The technology may speed healing time and shorten patients length of stay. However, SNFs have little incentive to adopt this technology because they are paid on a per diem basis. We don't expect this technology to increase SNFs' cost much over the next year, in part because they have little incentive to adopt it currently. We might consider ways in the future to incent SNFs to adopt this technology.

Next, I present three draft recommendations for your consideration. Our first recommendation, that Congress eliminate the update to SNF payment rates for fiscal year 2005. This would mean a decrease in spending relative to current law. Also, since Medicare payments currently exceed costs, we don't anticipating major implications for beneficiaries or for provider's ability to provide services.

Our second draft recommendation, even though we find that the current pool of money in the system is likely more than adequate, we continue to see problems with the distribution of moneys in the system as evidenced by the delays certain beneficiaries experience in accessing SNF services. Therefore, we propose recommending again, as we did last year, that the Secretary develop a new classification system for care in SNFs. And that until this happens, Congress give the Secretary the authority to remove some or all of the 6.7 percent add-on currently applied to the rehabilitation RUG groups and reallocate money to the non-rehabilitation RUG groups. We believe this would achieve a better balance of resources among all of the RUG groups.

Because this is a redistribution of money in the system, it would likely be spending neutral. However, it could potentially improve beneficiaries access to services, especially for those beneficiaries who currently experience delays in accessing services. And could lead to a more equal distribution of Medicare payments along providers.

Finally, our third draft recommendation relates to our efforts to monitor and ensure quality of care in SNFs. Although quality of care in SNFs appears to have been stable in recent years, GAO and others consistently find indications of overall low quality of care in nursing homes.

So that MedPAC and others might better study the

relationships between nursing costs, total costs, and quality of care, we propose recommending that the Secretary direct SNFs to report nursing costs separately from routine costs on the Medicare cost reports. I want to note that many state Medicaid programs already require nursing homes to break out these costs.

This recommendation would have no spending impact. It would likely have no immediate impact on beneficiaries, but it could mean a modest cost for providers.

This concludes my presentation. I welcome your questions or comments.

MS. RAPHAEL: The area where I guess I had the most concern, and I'm not as sanguine as you are about quality remaining stable, because in the draft chapter I found it hard to differentiate a Medicare patient from a non-Medicare patient because it's sometimes the same patients, although at one point Medicare is paying and then on the next day Medicaid is paying. And you do say the nursing staffing levels have gone down and deficiencies continue to be high. I think the GAO study indicated 25 percent rate of deficiencies in nursing homes in the last survey. And then on some of the clinical conditions, like UTI, urinary tract infection, the rates have not shown improvement.

So overall, I don't feel that we can say with great comfort that quality has stabilized and is not a cause for concern. I do believe that in nursing homes, to some extent, nurses are a proxy for quality. Nurses and probably CNAs are an important proxy for quality. So I think that I would like to see some changes in how we cast that.

I don't know if you've also considered the new feeding assistant which is now permitted in nursing homes, and what we think the implications of that might be.

DR. SEAGRAVE: I don't know that we have any data on that yet.

MS. RAPHAEL: But I think that is partly in response to a sense of problems in staffing. Whether that's a good thing or a bad thing, I think is subject to future interpretation. But I think that's another example of concern that staffing levels are not what they need to be in nursing homes and that they continue to have shortages and high turnover rates.

MR. MULLER: Just a brief question. What percentage of the Medicare patients turn into Medicaid patients?

DR. SEAGRAVE: We have relatively old evidence on this. At one point it was thought that about 30 percent do. It may be higher recently.

DR. REISCHAUER: I think the right number that we want is what fraction of the Medicaid patients are dual eligibles?

MS. BURKE: [off microphone.] Duals are about 12 to 14

percent.

MS. DePARLE: Overall, but in the nursing homes don't you have a sense it's got to be higher than that? So they're not in there as a Medicare SNF patient per se.

DR. SEAGRAVE: We actually are working on developing that number. I don't have it for you yet but we are working on developing that.

MR. MULLER: Nancy-Ann, I misunderstand it then. When they first come in they can come in as Medicare and then when the 100 days is -- and then they become Medicaid.

MS. DePARLE: Eventually.

DR. REISCHAUER: [off microphone.] When we're considering Dave's concerns, we're treating them like Medicaid and somebody else, but we have a responsibility for them in another sense.

MR. MULLER: I understand. That's why the distinction -- just following up on Carol's point -- the distinction between Medicaid and Medicare patients, I think, is just a thinner line than we're saying.

DR. STOWERS: I'm probably a lone voice on this, but having seen some of our facilities that are really struggling along the way, and full well understanding that we're not trying to substitute the Medicaid payments in some of our states that have gone down, it seems like to me, and knowing that their costs have gone up and their liability costs have gone up, and all sorts of things, that are changed this last year, it seems like to me an update that would at least cover inflation and that kind of thing over the last year, the MEI or minus productivity or something, would at least keep this on some kind of a grade along the way, would keep us supplementing it at the same rate we have been along the way.

So it seems like going with no update at all is really backing off, in some way, from what we had been supplementing along the way. So I would think personally that we would give some kind of an update that would at least keep up with their expected increase in expenses. Because what you're showing is that over time their margin is going down. They were at 20 and now they're going down to 14.

DR. MILLER: This may not change your point at all, and I need to be clear about this. There was two administrative changes last year. They got the market basket increase last year. And then there was an adjustment in the way the market basket was calculated, that gave an additional 3 percent.

DR. SEAGRAVE: Right, it was a market basket forecast error correction for forecast errors that had occurred in 2000 through 2002. So they increased rates by 3 percent beginning October 1st.

And then they also increased them by an additional 3.26

percent for that market basket forecast error correction from 2000 to 2002.

DR. MILLER: And that's all reflected in the numbers that you're presenting here, is that right?

DR. SEAGRAVE: Right. As I said, the 14 percent number -- it's a little misleading to say that they were at 20-something and then went down to 14. The 19 percent margins for 2001, those contained those two temporary payment add-ons. Those are more or less as reported in 2001. So they contain those two temporary payment add-ons that, as you know, expired on October 1st of 2002.

So the 14 percent, we modeled that according to current law. So that does not contain those two add-ons, but it does contain that 6.26 percent increase that they just got. And that increase is permanently in the rate.

DR. STOWERS: As long as our supplement, which I agree we shouldn't be trying to carry the other big load, that this is just not a good time for us to be providing less overall.

MS. BURKE: Very briefly, because I'm essentially repeating, in part, what Carol and Ray have both commented on.

I am also concerned about the mixed story on the quality issue and indicators that suggest that they are substituting lower cost staff for higher cost staff translates into nursing aides for nurses, which I think in fact has a direct impact ultimately on quality, decreasing the number of therapy staff. I mean, all those, in my view, are not positives. They are, in fact, potentially negatives. The data that we saw in the sort of avoidance, the list of the avoidable admissions, has the smell of some issues occurring in either the nursing home side or the home care side in terms of the treatment of patients.

So understanding, if we can, the source of those patients may help us understand more fully what is occurring in nursing homes, and if, in fact, whether it's the pneumonias or the UTIs or whatever it happens to be if we, in fact, are seeing an increase out of the nursing home sector, that to me translates into there are real issues here.

So I am also very nervous about presuming that those margins -- I mean, it's Bob's point that there may be enough in the system and the question is whether it's getting to the right places. But I worry about every one of these, decreasing the number of units of therapy, decreasing the number of therapy staff, translating into lower cost staff, or higher cost higher qualified staff, are all things I think that are negatives. And I worry about presuming that all is well and treating it as if we've done the right thing.

DR. SEAGRAVE: Yes, and I think that's why I've indicated that the quality evidence is mixed and we are very concerned

about the quality. Part of the problem is that under the PPS, when they're getting a prospective rate, the incentives unfortunately are there to reduce the types of staff that you were alluding to and substitute lower cost for higher cost staff and those kinds of things. And those incentives are going to be there no matter what the payment rate is. That's part of the problem.

MR. HACKBARTH: I think in both the home health area and the SNF area that's a theme, that there may be some issues of concern about the care. There may be some reason for concern about how the payments are distributed.

Then you get to the question well, is higher update factors a solution for these problems?

DR. REISCHAUER: I was wondering if we could take a subsample of nursing homes that are highly dependent on Medicare and private pay patients and then ones that are heavily dependent on Medicaid, and look at whether there's substantial differences in staffing patterns, in trends in staffing patterns, in application of therapy, et cetera, et cetera.

And then we can determine to what extent this is sort of a fiscal pressure issue as opposed to the way we've chosen to pay these things and the differential incentives. Because it might be a more complex problem.

We discovered in the dialysis area that quality and cost didn't seem to be correlated. And it could be that margins and quality aren't correlated here. You'd want to look at that.

It's conceivable that we'd come up with some information that then would give some more muscle to Dave's concerns because there's still a lot of Medicare patients in Medicaid dependent nursing homes, and we care about their quality as well as those in the others.

DR. MILLER: I know we're able to, and I think you even did subset low Medicare share and looked at the margins. But to the question of whether you can actually look at the staffing ratios, I guess is that something that we even can do?

DR. SEAGRAVE: CMS does, on the Nursing Home Compare, they do list staffing ratios. And in fact, they break it down somewhat, I think, by RNs and other types.

So to the extent that we can have enough sample size between the two groups that Bob is talking about. I mean, I think we can look at it. It's not going to be super precise, by any stretch of the imagination, but we can maybe do a rough cut.

MR. HACKBARTH: Any other questions or comments?

DR. NELSON: I think Sheila made a really relevant point and from a physician standpoint oftentimes the question of whether to treatment the pneumonia or the dehydration in the nursing, in the long-term care facility, or transfer the patient

to a hospital was based on the question if I leave the patient here and order antibiotics and IVs and so forth, can you do it? Can you handle it?

And there's a certain amount of pride on the part of the staff and often, if they can do it they say yes, we can handle that. But if they say well, we only have one RN during the night shift and we just can't be sure that it will get done, then the decision is to transfer the patient.

So the clinical decisions are often not absolutely clear cut, and there are alternatives that are viable if the ability of the long-term care facility is adequate to provide what the physician needs.

DR. WOLTER: Last year, as I recall, in our recommendations we recommended some type of update for hospital-based SNFs if the reclassification system didn't come to be. And we don't have that margin data to look at this month. I guess we will next month.

I'm wondering if draft recommendation two is intended in some way philosophically to deal with that issue?

MR. HACKBARTH: Yes, why don't we include that when we come back in January. I don't think that was an intentional omission.

DR. MILLER: But it is also true that the second recommendation to reallocate the money is directed at this point.

MR. HACKBARTH: Any others? Okay, thank you, Suzanne.