APPENDIX B

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This appendix is our inaugural publication of a new MedPAC effort—an agenda on Medicare and health care data. We plan to make it an annual part of our June report. Data underlie most of MedPAC's work and are critical to the policy agenda at large. They do not often receive the emphasis they deserve. Data issues are central to payment policy decisions for Medicare specifically and the health care industry more generally. As a public program, Medicare must ensure that payments are sufficient to at least meet the costs of efficient providers in order to maintain beneficiary access to services. Data analysis is the best way to assess costs, track access, and evaluate the factors that have an impact on providers, beneficiaries, and taxpayers. Data shape the way we think about many of the most compelling policy questions. Since we believe that data availability and integrity are important issues for policymakers, we will use this agenda to highlight issues we and other data users face in completing health care policy analyses.

MedPAC, along with other government oversight and regulatory agencies, depends on available cost, claims, survey, and other data to conduct its analyses and develop payment and other policy recommendations. We examine many data sources and run a spectrum of statistical analyses in the effort to fulfill our statutory mandates to: (1) review and make recommendations to the Congress on Medicare payment policies; and (2) examine and report on issues affecting the Medicare program, including changes in health care delivery in the United States and in the market for health care services. MedPAC's ability to complete its mission depends almost wholly on access to relevant and accurate data. Health policy decisions are only as accurate as the data they are based upon.

At present, the data agenda provides a list of disparate data improvement areas. In this appendix, we have collected important data issues that can be organized into three Medicare-related categories: access, quality, and cost data issues, plus a fourth category on private sector data. We recognize that these issues are only a start and that other important data issues are not addressed (for example, the need to identify costs at the case level). In the future, this appendix may expand to contain a framework identifying the types of data needed for sound policy analysis on costs, access, and quality and criteria that could be used to set priorities. In the future, the appendix could also select a single data issue and explore in detail the specific barriers to data access and integrity, and document the costs of addressing the identified issue.

On a final note, the Centers for Medicare & Medicaid Services is the collector and custodian for most of the data we use. Data collection and dissemination is only one of its many responsibilities. Data availability and integrity can only be assured through the dedication of sufficient resources. CMS, however, has long struggled with a lack of adequate resources. MedPAC commends CMS for its efforts on data issues and notes the calls for increased support for the agency (Butler et al. 1999, GAO 2001, King et al. 2002).

## Monitoring access

In July 1998, the Medicare program began the transition to a prospective payment system (PPS) for skilled nursing facility (SNF) services. Home health services moved to prospective payment in October 2000. MedPAC uses a variety of measures in assessing the adequacy of payments under these systems, including margins and provider entry and exit. In the following sections, we address the need for access to timely and reliable cost data, which is extremely important in making these assessments. Equally important to the payment adequacy analysis, however, are data on beneficiaries' access to care.

In MedPAC's March 2000 Report to the Congress, we recommended that the Secretary conduct annual studies to identify potential problems in beneficiaries' access to care that may arise in the evolving Medicare program, particularly from the implementation of new payment systems in the various sectors (MedPAC 2000). For several years, the Department of Health and Human Services' Office of Inspector General (OIG) studied beneficiary access to SNF and home health services. The OIG reported on beneficiary access to SNF services annually from 1999 to 2001 (OIG 2001a, 2000b, 1999b, 1999c).[1] It also issued reports on access to home care from 1999 to 2001 (OIG 2001a, 2001b, 2000a, 1999b).[2]

The OIG did not issue a report on beneficiary access to SNFs in 2002 and has indicated that it does not plan to continue to in the future, nor has it continued its study of access to home health services. We believe that these studies provided an important piece of our assessment of access and payment adequacy and are concerned about their demise. While MedPAC is itself developing resources to provide more information on access to post-acute care, the OIG's work would provide an important parallel source of information on access. The ongoing series of such studies provides a baseline of access from the start of the SNF and home health PPS, allowing policymakers to monitor changes over time.

In its March 2003 report, the Commission recommended that the Secretary continue to conduct a series of nationally representative studies on access to home health and skilled nursing facility services (similar to the studies previously conducted by the OIG) (MedPAC 2003). Due to the importance of maintaining information on access, we reiterate those recommendations here. The Secretary should determine the frequency of future surveys and reports. As these payment systems mature, surveys may only be needed every few years.

## Assessing quality of care

Elsewhere in this report, MedPAC discusses mechanisms for improving quality of care for Medicare beneficiaries. As we describe in Chapter 7, most quality efforts depend upon relevant data. Regarding home health care services, two sources of CMS data could, if linked, further our understanding of the relationship between the care received and outcomes of care. These are the Outcomes and Assessment Information Set (OASIS) and the home health claims database.

The OASIS is an assessment instrument used to assess patient status and is unique to the home health setting. Information collected includes sociodemographic, environmental, support system, health status, and functional status attributes of adult (nonmaternity) patients. CMS collects and compiles home health payment claims in a different database. Keeping these two databases apart separates data on the quality of home health services from data on use. Linking these two streams could provide a potentially powerful source of information on the relationship between the amount and type of home health services beneficiaries receive and the outcomes of their care. Combined with cost information, such a database could be used to develop a picture of the truly efficient home health provider and relate changes in service use to changes in outcomes.

CMS has begun work on just such a database, linking data on use with quality data. We strongly encourage the agency to continue this project. To make this linked database as useful as possible, we make several suggestions. First, the data should be compiled as close to real time as possible. Use of home health care has changed rapidly; timely information is key to reacting appropriately to emerging trends. Further, the data should include the OASIS assessment of patients at discharge, so that improvement or stabilization of condition during patients' care can be measured. Finally, the linked database should be made available to the wider research community.

## Assessing costs of care

### Physician practice expense

The Medicare program pays physicians under a fee schedule representing the resources used in furnishing a service. Resource amounts are based on national uniform relative value units (RVUs). There are three types of RVUs in the fee schedule calculation: physician work, practice expense, and malpractice expense.[3] For services provided after January 1, 1999, CMS has used what it calls a top-down approach to calculating the practice expense RVUs, based on data from the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS), along with data collected

1 The OIG based these reports on claims analysis as well as surveys of hospital discharge planners, nursing home administrators, and others responsible for assessing residents' needs.

2 The OIG based the 2001 reports on early 2001 surveys of hospital and nursing home discharge planners, as well as physicians and community representatives, after the home health prospective payment system (PPS) had been in place for about six months. The OIG based the 1999 and 2000 reports on survey information gathered before the implementation of the home health PPS.

3 At its most basic level, the fee schedule calculation consists of the product of the RVUs, a geographic adjustment factor to account for geographic variation in input costs, and a conversion factor which translates the other values into a dollar figure.

through expert panels.[4] The most recent SMS data on practice expense are from 1999.

The AMA conducted a scaled-down survey in 2001, collecting data from 2000 with less detailed expense information than the SMS. These data do, however, contain the necessary components to enable CMS to calculate the practice expense RVUs. The AMA is currently looking for partners to help fund the survey in future years.

If CMS continues to use the top-down methodology to determine practice expense values, a data source to replace the SMS must be assured. One option for collecting such data would be for the agency to pursue a collaborative approach, perhaps involving the AMA, physician specialty societies, and the federal government.

## Ambulatory surgical center costs

Medicare pays the facility costs of ambulatory surgical center (ASC) services on a fee schedule. The law authorizes the Secretary to determine which procedures may be payable when provided in an ASC and requires that the fee schedule, also set by the Secretary, take into account the costs incurred by such centers in providing services in connection with such procedures.[5] In 1994, the Congress required the Secretary to determine costs through a survey of a sample of representative procedures and facilities, to occur not later than January 1, 1995, and every five years thereafter.[6] These data are to be used to revise the ASC payment rates.

Payment for ASC services began in 1982. Initial ASC payment rates and subsequent rate revisions were based on agency surveys conducted in the early 1980s and in 1986.[7] In 1994, CMS conducted the survey required by the Congress. CMS issued the revised ASC rates in 1998, as part of a proposed rule that also sought to restructure the ASC payment system to make it more consistent with the outpatient hospital prospective payment system, then under development. The proposed payment rates were based on the 1994 cost survey data.

However, the Congress delayed implementation of the restructured payment system and required that CMS base the payment rates on cost survey data from 1999 or later.[8] As of early 2003, CMS has not completed the new cost survey needed to revise the ASC payment rates.[9] Thus, current payment rates are based on a 1986 cost survey and are probably no longer consistent with ASC costs.

The lack of current ASC cost data makes it difficult for CMS to set accurate rates. It presents further issues for policymakers in attempting to assess the adequacy of the current ASC rates. Collection of this information is vital. As we recommended in our March 2003 report, the Secretary should expedite the collection of recent ASC cost and charge data so that CMS can analyze and revise the ASC payment system (MedPAC 2003).

## Cost report data

Any discussion of cost reports must begin with an emphatic statement of the continuing need for the information contained in these filings. The movement to prospective payment for many service types has caused many to question the ongoing need for filing cost reports. Although prospective payments are not directly based on a facility's costs, cost information is a significant input into determining the rates paid under PPS and figures into the calculation of updates and adjustments to that system. Policymakers must recognize the importance of this data source. While others suggest that the cost reports be streamlined, we do not address this issue here. Our intent is to focus on near-term issues of cost report data availability.

The move to prospective payment and resource constraints have raised concerns over the timeliness and accuracy of cost report data, which are of paramount concern for policymakers. Data must be sufficiently recent and accurate to reflect providers' current financial status in order to assure adequate payment levels and beneficiary access. For Medicare data on provider costs, both timeliness and integrity are currently at issue.

The extent of the lag between data collection and access has varied. It is unclear whether there is a continuing

4 Clinical Practice Expert Panels (CPEPs), convened by a CMS contractor, met twice during 1996. A 1996 survey effort by the same contractor to gather additional practice expense data was discontinued due to a poor response rate. CMS is currently refining the CPEP data through a public-private partnership with the AMA and other physician specialty societies.

5 Sec. 1833i of the Social Security Act.

6 Sec. 141 of the Social Security Act Amendments of 1994, P.L. 103–432 (Oct. 31, 1994).

7 Medicare began paying for services provided in ASCs in 1982, pursuant to an amendment contained in the Omnibus Budget Reconciliation Act (OBRA) of 1980, P.L. 96–499 (December 5, 1980). The Secretary based the initial payment rates on a survey of ASC cost and charge data from 1979 and 1980. A second survey was completed in 1986 to update the payment amounts. While the text of the law did not then require the Secretary to use surveys to determine costs, the legislative history accompanying OBRA–80 stated the Congress's expectation that surveys be used.

8 See section 424 of the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000, P.L. 106–554 (December 15, 2000). The legislative history to this provision indicated the Congress's understanding that CMS was then (in 1999) conducting a new ASC cost survey that would better reflect the current costs experienced by ASCs.

9 The agency developed a survey instrument but has not yet fielded the survey.

increase in the lag time or whether independent events have caused recent delays in access. Under a cost-based system, providers were less at risk and policymakers less pressured to immediately assess data to determine trends. Under prospective payment, both providers and policymakers need to track payment adequacy. Policymakers track it to ensure payment rates are consistent with the costs of efficient providers and to evaluate whether beneficiaries have access to needed services, so they can act quickly if problems arise.

A number of events have made the release of cost report data more difficult. With the complexity of legislative and regulatory changes that came with and followed the Balanced Budget Act of 1997, the Congress has granted providers a variety of extensions for filing cost reports. In addition, data release has at times been delayed as CMS has struggled to maintain the pace of cost report processing, including auditing functions that must be done prior to data release. These difficulties appear to stem from increased and competing responsibilities addressed by the agency, resource limitations, and retirement of some key CMS staff.

The difficulties experienced by CMS have an impact on the timing of data availability and may also affect its soundness. Auditing ensures data integrity, which must be a priority. Again, cost data is a significant piece of the calculations for determining the adequacy of payment rates and, in turn, access to care for beneficiaries.[10] We strongly encourage CMS to prioritize its responsibility for maintaining the timeliness and integrity of the data. We further note that the resources to carry out this responsibility must be provided by the Secretary and the Congress.

### Use of early sample to facilitate access to data

To facilitate expedited access to cost report data, one mechanism to explore is the collection of an early sample of provider cost reports. This could be accomplished by requiring or paying a representative sample of providers to file their cost report information early. Perhaps these providers would submit a scaled-down version. In either case, CMS and the fiscal intermediaries would need to commit to quickly processing and auditing this information.

A number of questions would need to be addressed to make this process work. Providers use different fiscal years in tracking their costs. How could this be accommodated in gathering the early sample? Would varying fiscal periods bias the data? Would payment for early completion bias the information reported? CMS, MedPAC, and other researchers would need to explore all of the ramifications of using an early sample to ensure that the resultant data are reliable and unbiased.

CMS recently took steps to expedite access to cost report data. The agency has changed the format of the cost report data to relational databases. While this format provides access to all of the data collected by CMS, it may raise hurdles for researchers who worked with the previous format. The agency has agreed to issue hospital and skilled nursing facility cost report data in the previous format, on a short-term basis, perhaps to enable researchers to transition to the new system. While we commend CMS for these efforts, we believe it should provide several data formats during the transition, and ensure technical support once the relational databases are finalized.

## Access to private payer information

In addition to tracking providers' Medicare costs, policymakers must monitor developments in the health care market at large to gauge factors that could affect the Medicare market and providers' ability to serve beneficiaries. More specifically, information on private payer rates could help in assessing the adequacy of Medicare fee-for-service payment rates.[11] These data would help Medicare calibrate its payments, whether through its current administered pricing systems or through competitive pricing.

There are a number of possible sources for such information, most notably the Federal Employees Health Benefits Program. A number of states also collect private payer data. Assessing such data would raise a number of issues. Differences in benefit design and demographics could limit the ability to make comparisons. Confidentiality of business information would also need to be ensured. However, the need for a consolidated source of information on rates paid by private payers calls for these and other potential problems to be resolved. ■

10 Some associations, including the American Hospital Association (AHA) and the American Medical Association (AMA), used to survey their members on a range of information, including costs. These surveys had provided a wealth of information for both association members and policymakers. Both the AHA and the AMA have, however, discontinued some of those survey efforts.

11 The Commission has tried to gather information on private payer rates. We were unable to complete a national survey, pursued in 1999, due to a poor response rate. More recently, we gathered limited private payer data on physician payments through claims analysis and a small-scale survey.

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