

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, October 29, 2004
9:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA

Update first results:

Hospital

-- Tim Greene, Jack Ashby, Dan Zabinski, David Glass

Physician

-- Cristina Boccuti

SNF

-- Kathryn Linehan, Sally Kaplan

Outpatient Dialysis

-- Nancy Ray

MR. ASHBY: Every year MedPAC develops update recommendations for the payments in several fee-for-service sectors for the next fiscal year. And that, as a reminder right off, is fiscal year 2006 in this case.

We start by looking at several factors to assess the adequacy of factors in 2005. A reminder here, too, we're only three weeks into 2005, but we will be looking at that as the current year.

We typically look at six factors in this assessment. They are beneficiaries' access to care, supply of providers, volume of services, quality of care, providers' access to capital and the current year margin. The margins data will not be available until December, but we do have preliminary information on some of the other sectors. And given the workload that we have for December, we wanted to go ahead and get started.

Obviously, we have less than an ideal amount of time this morning for this work, so we thought we would first try to economize on our presentations, and we will do that. But secondly, we would like to suggest that perhaps we hold discussion after each one of these four presentations to questions of clarification.

Then, if there's any time that at the end, we can have a more general discussion but we'll keep things moving in that way

MR. HACKBARTH: I think that's a good idea.

MR. ASHBY: So with those ground rules in mind, I will go ahead and turn to the hospital sector.

First. just a reminder that we developed separate updates for inpatient and outpatient services. That's what we're going to be about in the hospital sector. But we make a single determination of payment adequacy for the hospital as a whole. We won't go into that detail, just something to keep in mind.

This morning we're going to have information on the factors that you see listed in this first slide and moving right ahead to access to care. We use changes in the number of hospitals over time as well as the breadth of services that those hospitals offer as our indicators of access to care.

In this first chart, we're looking at the percent of hospitals that offer various hospital outpatient services. You can see that the proportions grew slightly in the late '90s and have generally held constant since.

These next two charts show the proportion of hospitals offering a set of specialty services that cut across inpatient, outpatient and ancillary services. The proportions on this first page have grown in every case and I would point out that that includes burn care and trauma, services that have traditionally been viewed as among the least likely to be profitable. The increase in the share for trauma centers is particularly healthy, from 26 to 34 percent.

Then continuing, the services in this slide also increased in proportion except in psych services, where it dipped slightly from 50 to 40 percent. So in sum, we found in 13 of the 14 services we looked at that the proportion of hospitals offering the service has grown or stayed the same.

Next we look at hospital participation rates and that's Tim.

MR. GREENE: We examined changes in the number of hospitals participating in the Medicare program and providing care to Medicare beneficiaries. We found that in 2003, for the second year in a row, more hospitals began providing care than closed. 41 facilities ceased participating as acute care hospitals and closed. There were 58 new participants of which 28 identified themselves by name as specialty hospitals. They described themselves as surgical, specialty, orthopedics, heart or women's facilities.

Concern that closures in rural areas might impair access to care for Medicare beneficiaries led the Congress to enact the Critical Access Hospital Program and the BBA. Since then approximately 1,000 hospitals converted to CAH status. The program now plays an important part in maintaining access in rural areas. We looked at conversions to CAH status in 2003 and found that more hospitals converted to critical access hospital status than closed. Of 157 hospitals that ceased participating as acute hospitals, 116 became CAHs and 41, as I indicated a moment ago, closed and stopped providing care.

I will now turn to indicators of volume, changes in volume in hospitals.

The rate of increase in discharges for both Medicare and all payers increased after 1998, peaking at 4.6

percent for Medicare in 2001 and 3.3 percent for all payers in 2000. The change in Medicare discharges in part reflects changes in enrollment. Fee-for-service enrollment grew in 2001 and 2002 as many beneficiaries left Medicare+Choice plans and returned to fee-for-service. This is reflected in 2001 and 2002 in a sharp increase in fee-for-service discharges at PPS hospitals that you see here.

Discharge growth continued afterward with Medicare discharges increasing 2.4 percent in 2003 and all payer discharges 1.4 percent. In the case of Medicare, that keeps discharge growth still in excess of fee-for-service enrollment growth, which was 2.3 percent in 2003 when discharges increased 2.4 percent.

The average length of stay of Medicare patients fell more than 30 percent during the 1990s. Peak declines occurred in the mid-'90s with drops in excess of 5 percent per year from 1993 to 1996. Length of stay decline moderated after that but has increased again after 2002 and we see a decline in Medicare length of stay of 1.3 percent in 2003.

Pattern of length of stay decline for all payers generally moves the same way as Medicare length of stay change but is historically more moderate. Here we see modest all payer length of stay decline, an actual increase of 0.2 percent in 2002 and no change at all in all payer length of stay in 2003. You see no number there because all payer length of stay change is zero in 2003 compared to the 1.3 percent decline in Medicare length of stay.

MS. BURKE: What is the number now? How many days?

MR. GREENE: About six, a little below six. I don't remember exactly.

DR. REISCHAUER: Because all payer includes Medicare and Medicare is a big chunk of the all payer, the difference between Medicare and non-Medicare is really much, much larger. In fact, in some of these years would be of a different sign, particularly in 2001. I would think, in a way, it might be more useful to try and do that, although the non-Medicare would have the Medicare+Choice people in it is the problem; right?

MR. ASHBY: Part of the reason we don't do that is because the non-Medicare number is a real mixture that actually includes some Medicare, as you say. So it's a funny number.

MS. BURKE: Jack, remind me again, what percent of hospital admissions are Medicare? The full boat.

MR. ASHBY: Approximately 40 percent of all types of Medicare, which is broader than the Medicare measure that you're looking at.

DR. ZABINSKI: Moving away from inpatient volume, I'm going to discuss volume in the outpatient PPS.

In the March 2004 report we measured volume in the outpatient PPS as the number of services provided rather than number of visits because the outpatient PPS pays on the basis of services. This means we count number of biopsies performed, number of MRIs done, number of radiation therapies and so forth. We'll continue to use this measure of volume in the March 2005 report.

Using claims data, we have found that volume has grown strongly since the outpatient PPS began in August of 2000. For example, overall volume of services grew by 8.4 percent from 2002 to 2003 and by just 13 percent from 2001 to 2002.

A couple of notes on these findings are first of all that they exclude pass-through devices, pass-through drugs and other separately paid drugs. We made this exclusion because nearly all devices and drugs on the pass-through list in 2002 had their pass-through status sunset at the end of 2002. Therefore, the volume for pass-through drugs and devices dropped substantially in 2003 because most were packaged with services rather than being paid separately as they were in 2002.

A second point is that about two-thirds of the increasing in volume from 2002 to 2003 is due to increased volume of care per beneficiary who receives outpatient PPS services. And then most of the remaining growth from 2002 to 2003 was due to an increase in the fee-for-service beneficiary population.

And now David is going to discuss hospitals' access to capital.

MR. GLASS: One of our indicators of payment adequacy from the payment adequacy point of view is the aggregate amount about right. Industry plans on their use of capital, this is from a 2004 Bank of America Security survey for nonprofit hospitals. They forecast a 10 percent increase in capital spending. 41 percent of the hospitals actually expected to increase the capital spending more than 15 percent. So they're planning on having access to capital.

The HFMA also found a 14 percent annual increase over the next five years versus only 1 percent from '97 to 2001, so they too are forecasting access to capital

Nearly 82 percent of hospitals actually plan to increase capacity, that is expand capacity, get bigger bricks and mortar sort of thing. And 54 percent plan to increase inpatient capacity. And other sources concur in that, that there is a move towards increasing capacity.

Nearly 87 percent report access to capital is the same or better than five years ago. Interestingly, 94 percent of rural hospitals report that to be true. So they expect to have capital available.

This shows hospital construction spending from Census Bureau data. As you can see, it's gone from about \$13 billion in 2000 up to \$20.5 billion in 2004. The change in 2003 to 2004 is about 12 percent. So we look at what they expect to do, this is what has happened up until now, and the construction spending clearly has been strong, capital has been used.

Looking at tax-exempt hospital municipal bond issuances, these are for nonprofit hospitals, 2004 is the second highest in total over this period, starting in 1994. Interesting, new money, which is the darker part of the bar, is at its highest level for the entire period, over \$20 billion. So they're not just refinancing to get lower interest rates, they're actually getting new capital.

The interesting point is that all of this borrowing has not lowered the median credit ratings, that operations and other income can support the additional borrowing without lowering key ratios such as debt service coverage and days cash on hand. Downgrades still outnumber upgrades but the dollar value of upgrades in the last quarter, according to one of these sources, exceeded the value of the downgrades by 70 percent. So more money was getting upgraded than downgraded, even though the number of hospitals was the other way around. And it could still be that smaller hospitals are downgraded more but the vast majority are unchanged, they're neither upgraded nor downgraded.

There are also hospitals that do not issue publicly traded bonds, so they could have other capital access problems. But interesting, other forms of financing are available as well. Banks are moving more into this area and their private placement tax-exempt bonds are increasing and there are also groups that are now securitizing small tax-exempt bonds and selling them as packages to investors. So there are other sources of capital that are showing up that we wouldn't be able to track from this kind of data. Also of course, the hospitals can lease equipment which doesn't show up as debt and doesn't show up as borrowing.

For-profits, of course, can issue equity directly. Recently one announced that they're borrowing as much as \$2.5 billion to repurchase shares, so they seem to have sufficient access to capital there. We'll revisit the findings if new numbers come up that change any of these.

MR. HACKBARTH: Under your proposed approach, we're going to turn to physician next?

MR. ASHBY: Questions or clarifications? If none, then we will skedaddle.

DR. MILSTEIN: Relevant to some of our prior discussions, do we know anything about the relative rate of investment in new hospital capacity in what Elliott Fisher would suggest are the high volume, high cost regions of the

country versus low volume? That's question one.

Question two, and maybe relevant to our IT discussion yesterday, do we know very much about the degree to which this capital that is being raised is being deployed? What's its relative use in terms of deployment for bricks and mortar versus IT and other things that might be used to improve hospital performance?

MR. GLASS: I think we have some information on the latter, at least what the plans were, whether they were going to use it to invest in technology. We can get that to you.

DR. CROSSON: Relative to the upgrading or downgraded, and I know the data shows that most hospitals don't change in a given year, but there was a significant number moving in each direction. I wondered, do we know by hospital type who was being moved up, who was being moved down, hospital size, ownership, public hospitals, academic hospitals, for-profit chain hospitals?

MR. GLASS: We can probably put something together on that.

MR. ASHBY: We don't have it right now.

MR. GLASS: The larger systems, I think, tend to be more stable than individual hospitals.

DR. MILLER: But the sources of this analysis that we have often don't break it up into the usual categories that you are use to looking at, teaching, nonteaching, that type of thing. We can infer it often from pieces of what we read but I suspect it won't be a nice table, quantifying it by category of hospital.

MR. GLASS: Unless we want to go into it hospital-by-hospital and count them. We could do something like that, I think.

DR. MILLER: Do you actually have the capability of doing that, including time?

MR. GLASS: We can try. Time, maybe not.

DR. MILLER: I think that's the point I'm driving at.

MR. HACKBARTH: We have to move ahead to the physician.

MS. BOCCUTI: I have a very brief presentation on results from some recent surveys on beneficiary access to physician care and, of course, a more comprehensive analysis on access to physician care will be in December.

The first study I'd like to discuss was sponsored by CMS and conducted in 2003. It's called the targeted beneficiary survey because it surveyed beneficiaries in market areas where rates of reported physician access problems were highest in the 2001 CAHPS fee-for-service survey.

The study found that even in these areas suspected of higher than average access problems, only a small

percentage of beneficiaries had access problems attributed to physicians not taking new Medicare patients.

Specifically, the study found that within these 11 markets, only 90 percent of beneficiaries reported that they were able to get a personal doctor they were happy with since joining Medicare. Similarly, over 90 percent of those needing a specialist reported no problems seeing one in the past six months.

Ability to get timely appointments was a little more problematic in these areas but still not bad. 73 percent reported always getting an appointment as soon as they needed and 20 percent said they usually did. So that leaves about 7 percent who reported that they sometimes or never were able to get timely appointments.

Less than 4 percent of beneficiaries reported that problems accessing physicians were due to physicians not taking Medicare patients or not taking assignment. Other reasons beneficiaries gave for access problems included that the doctor was not taking any new patients or didn't like the doctor or they had transportation issues.

And finally, access problems were a little more problem for transitioning beneficiaries in these areas. Transitioning beneficiaries are those that are new to Medicare or recently disenrolled from a Medicare+Choice program, or new to the market area in general. These beneficiaries had higher rates of access problems, finding a personal doctor and a specialist. In some respects, that can be expected. I think the survey was careful to oversample that group to get a really good sense of what their experience was.

Next, I'm going to turn to a MedPAC-sponsored survey which was piloted last fall which you may recall that I talked about. We conducted it again this year, just this past August and September. Although we did not target specific areas, we expanded on our pilot survey by including privately insured people aged 50 to 64 to allow some comparisons between these populations, that is the Medicare population and the people aged 50 to 64. We hope to continue tracking these trends with both these groups.

Results from this telephone survey showed that the majority of Medicare beneficiaries and people aged 50 to 64 reported either small or no problems with access to physicians in 2004. Access to physicians for Medicare beneficiaries is the same as or better than that for privately insured people aged 50 to 64. Differences in Medicare access between 2003 and 2004 were not significant.

So I'll talk about a bit about these specifics. Looking at the last two columns, both the Medicare and privately insured groups reported more difficulty finding a new primary care physician than a specialist but the

majority, that's 88 percent which is the sum of the no problem and the small problem group, reported that they experienced small or no problems finding a primary care physician. Regarding specialists, 94 percent of Medicare beneficiaries and 91 percent of privately insured individuals reported the little or no problems accessing specialists.

Looking at the first two columns, which track access from Medicare beneficiaries from 2003 to 2004, the difference between the two columns is not statistically significant, though keeping track of possible increases in the share reporting the big problems will continue to be important. And also looking at the 2003 Medicare column, I want to mention that the results from our survey were very consistent with relevant indicators from the CAHPS fee-for-service, which came out recently, and that was for 2003. So we have 2004 results but the recent 2003 results for the CAHPS study are similar to what we found last year.

When asked about difficulty getting an appointment as soon as that they wanted, respondents indicated that for routine care Medicare beneficiaries fared slightly better than the privately insured group. And 73 percent of Medicare beneficiaries and 66 percent of privately insured individuals reported that they never had to delay their appointment. But 2 percent of Medicare beneficiaries and 3 percent of privately insured individuals reported always experiencing a delay.

As expected for illness or injury, delays are more common for both groups but I didn't put that up on the slide.

Another measure of access also not on the slide that many surveys use examines whether people saw a physician when they thought they should have but that they didn't. In our 2004 survey, 6 percent of Medicare beneficiaries and 11 percent of privately insured individuals said that they think they should have seen a doctor for a medical problem in the last year but that they didn't.

Within this group, physician availability issues such as finding a doctor or getting an appointment time were listed as the problem for really only a small share of those people that said that they didn't see the doctor. More common responses for these people were that they didn't really think the problem was serious enough or that they had cost concerns or that they were really just putting the problem off or reporting off making an appointment.

So that concludes what I'm showing you today. In December, I will complete the access analysis with a little bit more looking at physician willingness to serve Medicare beneficiaries. And that will be part of the whole of payment adequacy analysis.

MR. HACKBARTH: Before we move on to SNF, any clarifying questions on the physician?

MS. DePARLE: I had one but this is going to make you go back to your slide. Page four of your slides.

I think you comment a little on this, but do we need to be concerned about the primary care physician, the change between the 2003 and 2004 of those number of beneficiaries who said it was a big problem?

DR. MILLER: That's exactly why -- we went through a lot of this in talking about how to display, because you've got tons of information here. We wanted to bring this up specifically because there's a couple of ways to look at it.

When you compare it to the 50 to 60, Medicare still seems to be doing better. And also, even the split over time is a little bit funny. The no problem got better, people saying they had no problem got better. And then the people with a problem got worse.

And so we wanted to flag this for you. There's no statistical difference but there is a jump in that number. And that's what Cristina said, that this is probably an area that we need to keep an eye on. But it is a little bit anomalous because you've got the people with no problem, more of them saying that there's no problem too, at the same time.

MS. BOCCUTI: I'll mention also that the 18 and 11 is small but it's just on the cusp of being statistically significant. It's probably in the 90 percent confidence.

But the issue with the primary care physicians is we're really looking at people who are trying to get a new primary care physician and this reduces your N a lot because they have more experience trying to get a new specialist because they have a new condition. But the statistical significance -- but when we look at the other surveys, it's relatively consistent.

But I didn't want to blow over what you raised by saying that we're going to keep tracking this and if there's fluctuations over time, then these are within the range of similar. But if there's a trend that keeps continuing then, if we always track it back to 2003, if say in 2007 it becomes a trend that's wildly different from 2003, we'll know that.

MS. DePARLE: I guess I'm trying to remember from the earlier work the number of physicians who say -- there's one number of physicians who are participating, then there's a number of physicians who will take new patients and a number who will take new Medicare patients. What I remember is that hadn't changed much. But I'm just wondering to what extent is this a proxy for a change there, because that's obviously something we would be concerned about.

MS. BOCCUTI: Right, and that's why we try -- we

couldn't do it today because we're trying to collapse everything, but to always balance this with the physician willingness to take new patients. And we try and look at that, too. And that's sort of what you're going at, but this is a beneficiary access survey.

MS. DePARLE: I'm just wondering if that change -- and I hear you saying it's not statistically significant, although it looks like a sort of large number -- does that, in some way, indicate something about physicians willingness to accept new Medicare patients?

MS. BOCCUTI: We'll keep that in mind as we continue the analysis and we'll be able to track it over years.

DR. MILLER: Cristina, do we plan in December to talk about the other data sources, which would include that?

MS. BOCCUTI: Like caseload issues?

MR. HACKBARTH: No, physician willingness to accept new Medicare patients.

MR. MILLER: Isn't that one of the other surveys?

MS. BOCCUTI: The sources that we look at, typically we have the NAMCS, which is the National Ambulatory Medical Care Survey. And that won't give us 2004. And hopefully we'll have it in time to look at 2003.

So the tricky part is that we're happy that we have such recent data but it's never going to be in any of the other surveys that we provide. We try and track that every time, physician willingness, with whatever sources we can obtain.

DR. NELSON: Cristina, if it's possible to break out your numbers for Medicare patients over the age of 70 and under the age of 70, pick a number, but I'd be reassured if we didn't see a difference in access problems from the 66-year-old relatively healthy semi-retired businessperson from the frail elderly person with multiple chronic illnesses.

MS. BOCCUTI: Actually, some of the data is cut that way for our analysis, so I'll see what I can do about doing that. I understand your point and the discrepancy in the full Medicare population ages compared to the 50 to 64. I'll look at that.

DR. REISCHAUER: Just a question of clarification. Is this a question asked of all Medicare beneficiaries or those who are looking for a new primary care physician?

MS. BOCCUTI: The first question about primary care physicians? That is only asked if you were looking for a new primary care physician.

DR. REISCHAUER: And what fraction of total Medicare participants is that? Is it 10 percent?

MS. BOCCUTI: A little under 20, I think. I need to look at that number to be sure.

DR. MILLER: This is 11 percent of 20 percent is

what it is, so we're talking about small numbers.

MS. BOCCUTI: But I have to check that number.

MR. HACKBARTH: Thanks, Cristina.

MS. LINEHAN: First, we're going to look at entry and exit of SNF providers. Data from 2004 indicate that the trend in the supply of SNFs we've seen for the past few years continues. From 2003 to 2004, the total number of SNFs participating in Medicare remained almost unchanged, with the number of hospital-based SNFs declining 6 percent and the number of freestanding SNFs increasing by 1 percent. These changes in the past year tracked very closely with the average annual change in the supply of SNFs over the past five years. In 2004 the number of SNFs is about the same as it was in 1999, the first full year of the PPS.

The next factor we'll consider is the volume of SNF services provided in 2002, which is most recent year for which we have data, and it's an update from what you saw last year, which is 2001 data.

Between 2001 and 2002 the overall volume of SNF services increased, discharges covered and average length of stay all increased. Total payments to SNFs increased while the average payment per day actually declined. This follows a 13 percent increase in average payment per day between 2000 and 2001. The expiration of some temporary payment add-ons affected payments in the last quarter of 2002. Other payment add-ons will remain in place until the implementation of case-mix refinements to the SNF PPS.

Looking ahead to 2004, SNF spending will also be affected by the full market basket update plus the administrative increase to correct for past market basket forecast errors.

The CMS Office of the Actuary projects that Medicare spending on SNFs will be \$13.5 billion in 2003 and \$14.3 billion in 2004.

Next, we're going to look at access to care. Our primary source of information has been OIG studies on discharge planners ability to place Medicare patients in a SNF after an inpatient stay. Consistent with the MedPAC recommendation, the OIG is currently conducting of a follow-up to this study but they won't have results until spring of 2005 so we can't consider them for this year's update. So ideally, we'd have this information, but instead I'm going to present information on case-mix that shows that the same types of patients are accessing SNF care between 1999 and 2002 and some data on utilization to show that utilization has increased.

Past OIG studies from 1999, 2000 and 2001 of discharge planners ability to place Medicare beneficiaries found that those needing rehab therapies have ready access to SNFs but those needing other types of services might experience delays in accessing SNF care.

Another OIG study on the change in case-mix between 1999 and 2002 -- and case-mix is measured by the assignment of one of 44 RUGs - indicates that SNFs continue to treat the same mix of patients with slight shifts towards rehab and extensive care and a small decrease in the proportion of patients in special care and clinically complex RUGs. More than three-quarters of SNF patients continue to be assigned to rehab RUGs.

Assuming that the need for different types of SNF care hasn't changed markedly, this suggests that those types of patients that had no difficulty accessing care in 1999 may have had similar access in 2002 and that those expressing delays in 1999 may have also experienced delays in 2002.

Next, we're going to look at some of the results from Chris Hogan's work that he presented last month on benes' use of post-acute care. He found that the number of SNFs episodes increased between 1996 and 2002 and that the proportion of discharges to a SNF increased between 1996 and 2002.

Ideally, we'd have information on whether those who need SNF care can get it as our measure of access. But these data suggest that since the implementation of the PPS, more beneficiaries are using SNF care. In addition, the minimal change in the assignment to RUGs suggest that SNFs are providing a similar mix of care in 2002, similar to the mix that they provided in 1999.

Last, I'm going to turn to quality. In our previous meeting last month, we talked about our long-term quality agenda for SNFs. Today I'll present available evidence to examine quality trends specific to SNF patients from three sources for purpose assessing payment adequacy.

The first quality measure we'll look at is information about SNF patients adjusted readmission rates for five potentially avoidable conditions between 1999 and 2001. We're going to update this for 2002 with data that we just received. These five categories of readmissions to the acute care hospital from a SNF setting were developing by researchers at the University of Colorado Health Sciences Center and judged to be the types of readmissions that are avoidable if patients are receiving good quality care in the SNF.

After controlling for diagnosis and functional severity of patients, we found mixed results. Rates of readmission for congestive heart failure, electrolyte imbalance and UTI increased. We saw a decline in rates of rehospitalization for respiratory infection and the rate for sepsis remained the same.

Next, we'll look at again some work from Chris Hogan on quality for short-stay patients. He compared rates of mortality, readmission to the hospital and discharge to

community after 30 days in 2002 to those rates in 1996. As he explains, this is not the most refined measure of the performance of the system. It's a short-term outcome. It doesn't address the long-run. It doesn't address people who don't use post-acute care. It doesn't address functional status.

With that said, the 2002 expected numbers were based on what he predicted to happen based on the diagnosis of cases in 2002 and based on the outcomes in that post-acute setting that occurred on average for those cases in 1996. Again, here we see mixed results. Medicare beneficiaries in a SNF in 2002 had lower than expected mortality but greater than expected number of readmissions. And here, readmission is just a readmission after 30 days, any readmission, and lower than expected number of successful discharges to the community.

The last quality indicator we'll look at comes from CMS's Nursing Home Compared database. What you see on this slide are the median values for skilled nursing facilities on three quality measures for short-stay patients. It's important to note that these data are not weighted for the number of short-stay patients in the facility so these are facility rates.

There was no change in the percent of short-stay patients with delirium between 2002 and 2004, and a decrease in the proportion of SNF patients with moderate to severe pain. We can't present trend information on pressure sores because we only have 2004 data.

It's important to note that for each of these measures in each year about 30 percent of facilities didn't report data either because they just didn't report it or they had too few patients to report.

In sum, all of these quality measures show some improvements and some declines in quality but the changes, where they exist, are small.

This is all I have for this month. I can take clarifications or questions.

MR. SMITH: Just a quick question. I'm always a little confused by the number of SNFs rather than the number of beds as an indicator of what's out there. Do we know how many SNF beds there are relative to the previous year?

MS. LINEHAN: I don't have those data now. The complicating factor, in my understanding, is that facilities will certify all of their beds as Medicare beds. And so we'll know a total number of beds in the facility but not necessarily the number of beds that are being used by Medicare patients.

But I can look into getting information about that.

DR. REISCHAUER: But you have a very different picture of you look at covered days. It's going up like a

bandit and the number is sort of holding still. That could be filling excess capacity or what, you really don't know.

DR. SCANLON: Some information, essentially Medicare's only covering about 10 percent of facilities beds. So there is the flexibility to change over time, even though you're not certifying anymore. It was with the introduction of the PPS that facilities started to certify virtually all of their beds as opposed to maintaining a distinct part for Medicare purposes. And so we lost track in terms of what they want to do, in terms of service to Medicare patients.

MS. RAPHAEL: I had two questions. One is trying to understand what has led to the increase in the percentage of hospital discharges going to SNFs. I don't remember the exact number but I do recall that looking from 1984 to the present the percentage of those over 65 who are in nursing homes has declined. So I'd like to try to understand what is happening there, whether there's a redistribution in terms of rehab facilities in home health care or is it correlated in some way with the fact that you said more than three-fourths of the cases are for rehab services?

That leads me to the second question. I know you have little bit on that but one of the concerns we have had has been whether or not what we call clinically complex patients have access to the SNF. I can't entirely tell from this what's happening in that area but that seemed to be the patient group that we were most concerned about.

DR. MILLER: I think you're right. At least at this point we aren't able to parse that very well. Some of the recommendations that we made in previous years, for the IG to go ahead and look at this, is to hopefully get drilled down on some of that. I'm not aware that we have, and Sally, you should -- I'm not aware that we have a really good way to get the quality measure specific to the diagnosis in question. So we're reporting them at the aggregate level. We're a little bit stuck is the point.

DR. MILSTEIN: Triggered by this presentation but a little bit broader, this presentation and others for me stimulate the question what kind of a freshly populated measurement dashboard does MedPAC need to make good recommendations? Because some of this information -- and it's not obviously a staff problem. This has to do with information flow. But if we're expected to offer useful opinions but not, for example, have information on severity of illness and who's going in and out of SNFs -- to borrow Clem's metaphor, we've got a very cloudy windshield we're trying to steer through.

Both with respect to offering good recommendations on adequacy of SNF payments and probably across the board, if we thought about it, as we're discussing these individually we can be accumulating a list of what we might

than recommend in the future ought to be a regular fresh measurement flow into this organization so that we can offer more informed opinions.

DR. MILLER: And that's some of what we talked about last meeting when we were talking about the work plan for going through SNF quality analysis. We openly acknowledge that, particularly to distinguish facility-specific types of outcomes, that we have a problem. We've stepped back and articulated the direction we're going to go. And at an aggregate level, this is sort of what we have. We're hoping the IG comes online following recommendations that we made. But this is not to say no to you at all. We do get that.

MR. HACKBARTH: Anything else?

DR. WOLTER: This is sort of related. Is it possible to look any of these quality indicators, hospital-based SNF, and break it out that way, versus freestanding? It's a little bit related to this clinically complex patient issue in my mind.

MS. LINEHAN: Yes, it is. For this one it is, for adjusted readmission rates. For what it's worth, this one is, too. We can come back next time with that.

MR. HACKBARTH: Just one other thought about Arnie's question. I remember a couple of reports ago we did an appendix on data needs and at the time I thought we were thinking about that being if not an every issue feature but a regular feature with this intent in mind, sort of trying to look ahead in an organized way, saying if we could start to fill these holes it would not only help MedPAC, of course, but everybody involved in the program

So that's a thought that we may want to pursue.

Let's move on. Thank you, Kathryn. Let's move on to outpatient analysis

DR. RAY: Okay, we will close today's proceedings with a first look at indicators assessing outpatient dialysis payment adequacy. You will have opportunities at the December meeting and the January meeting to again reflect upon these data as well as additional data we'll be bringing to you.

Your mailing materials included four indicators of payment adequacy: looking at changes in the supply of providers, beneficiaries access to care, changes in the quality of care and changes in the volume of services furnished to beneficiaries.

In terms of the supply of providers, we've updated our data to include the number of facilities for 2003 and 2004. Between 1993 and 2004 the number of facilities has increased 6 percent per year. For-profit and freestanding facilities are a higher share of all facilities over time. And the share that are located in rural areas has remained

steady at about 25 percent.

Moving onto beneficiaries access to care, one way we look at access to care is to look at the pattern of facility closures to see if beneficiaries are facing systematic problems in getting care. To do this we compared facilities that stayed open and 2003 and 2004 to those that closed in 2004. Consistent with our results from previous analyses, a disproportionate number of facilities that closed were small, nonprofit and hospital-based.

Again, consistent with what we found, is that closures did not disproportionately occur in rural areas or in HPSAs. We used Bureau of Census data that measured racial, ethnic and economic characteristics of an area on the ZIP code level. And here we found that closures were not disproportionately occurring in lower income areas, again what we have found before.

Our new finding here, though, is that some closures may be occurring in areas where a higher proportion of the population is African-American. Here we found that 18 percent of the population were African-American in areas where facilities remained open versus 24 percent where facilities closed.

I want to caveat this measure. This is not a perfect measure because it's measuring in areas ratio and income characteristics, not the facilities. Nonetheless, we think it's important to continue to monitor trends here. In the future what we may want to do to more accurately look at this is to link patient claims, so we can get race, to where beneficiaries are being treated so we can do this analysis on the facility level.

In terms of quality of dialysis care, we used CMS's quality measures which show between 1999 and 2002 improving dialysis adequacy. This is hemodialysis adequacy and peritoneal dialysis adequacy and improving anemia status for dialysis patients. There is little change in nutritional status among both hemodialysis and peritoneal dialysis patients and a very small change in vascular access care.

Another aspect of quality that MedPAC has analyzed in the dialysis area is the relationship between providers' costs and quality. Just to remind you, back in June 2003 we used 2000 cost report data and we showed that no difference in the quality of care, in terms of dialysis adequacy and anemia status, between lower-cost providers and higher cost providers. We've updated this information, which was included in your mailing materials for 2001, and we found similar results.

Finally, in terms of the volume of services, volume is increasing. We look at volume in terms of spending to put it on a common metric here. MedPAC analysis between 1996 and 2002 shows that the growth in spending of

injectable drugs went up faster than dialysis spending. Injectable drug spending went up about 17 percent per year. Dialysis spending, that's composite rate service spending, went up at about 6 percent per year. The multiple factors affecting injectable drug growth spending include increasing use of the drugs, higher cost for new drugs, and the increasing patient population.

By contrast, the utilization growth for dialysis services is limited because Medicare covers a maximum of three treatments per week. And so any increase here is limited to the growth in enrollment.

That concludes the presentation.

MR. HACKBARTH: Any questions or comments?

MS. DePARLE: I agree with your comment about data following the last presentation. This one reminds me that this is an area where we could have more timely access to data. and if there's something we could do about that it would be helpful.

Nancy hears this all the time, but the dialysis providers, many of them, say that they provide cost report data and they don't understand why it takes so long for us to get access to the more recent data. I don't know if there's anything we can say about that but I think it's something that we can agree with the industry on.

DR. RAY: Right, and I think my first cut of the analysis of the cost report data suggests that I'll have data for about 2002 and 2003, that we will have a sufficient sample this year. So that, I think, is the good news.

DR. MILLER: And Nancy, to that point, in our comment letter --

DR. RAY: Yes, and that's true, also. In our comment letter on the Part B reg, we actually did mention the need for up-to-date and timely cost report data.

DR. MILSTEIN: I may have missed this, but do we have access to information that would tell us about either differences between dialysis facilities or trends overall for all dialysis facilities with respect to the total costs of care associated with patients who are in renal dialysis? Things that would be giving us a clue as to the rate at which readmissions or admissions to hospitals are occurring for infections, et cetera?

DR. RAY: When you say total cost of care, do you mean both for dialysis and non-dialysis? Or dialysis and injectable drugs?

DR. MILSTEIN: The former, the works. In other words, things that would begin to give us an index of propensity of patients to get into trouble and require a lot of medicare payments and services that are not included or not even delivered by dialysis facilities or included within the dialysis facility rate?

DR. RAY: Yes, that's doable. We looked a little

bit at that in our June 2004 report where we looked at spending in the pre-ESRD period and one year into ESRD. But we can give some additional thought to that and get you back to on it.

DR. MILSTEIN: Thank you.

MR. HACKBARTH: Ralph's comment was that Jack Rowe, when he was on the Commission, often -- in fact, at every discussion of dialysis -- would urge us to think more broadly about the treatment being delivered and the overall cost, the overall quality.

Anything else?

Okay, we will have a brief public comment period.

MR. HACKBARTH: Seeing no one rushing to the microphone, we are finished. Thank you very much.

[Whereupon, at 12:02 p.m., the meeting was adjourned.]