

Study Reveals Shift In Elder Population

Less Poverty, More Education, Fewer Disabilities Are New Trend

A new study released by the U.S. Census Bureau reveals some surprising trends among older Americans' financial and physical well-being, such as greater longevity, lower rates of disability, higher degree of education, and a decline of individuals living in poverty.

In conjunction with the National Institute on Aging (NIA), the Census Bureau recently released "65+ in the United States: 2005," which provides a snapshot of the health and socioeconomic status of the aging population.

"Many people have an image of aging that may be 20 years out of date," said NIA program Director Richard Suzman. "The very current portrait presented [in this report] shows how much has changed and where trends may be headed in the future."



Among the most striking findings is that the proportion of Americans with a disability fell from 26.2 percent in 1982 to 19.7 percent in 1999. Nearly 80 percent of seniors have at least one chronic health condition such as arthritis, hypertension, heart disease,

or diabetes, and 50 percent have at least two chronic conditions that limit their activity.

According to the survey, among the 14 million civilian noninstitutionalized older individuals, women were more likely than men to experience disability: 43 percent versus 40 percent,

respectively.

Americans also are living longer than ever before. The average life expectancy at birth rose from 47.3 in 1900 to 76.9 in 2000.

Older Americans are also in better financial shape than they were nearly

50 years ago. The percentage of people aged 65 and older living in poverty decreased from 35 percent in 1959 to 10 percent in 2003—mostly attributable to Social Security, the report said.

However, there does remain some disparity in income and wealth between men and women in this population. Women aged 65 and older received an average \$8,224 annually as pension income, while men received \$14,046.

The report asserts that higher levels of education, which are linked to better health, higher income, more wealth, and a higher standard of living in retirement, will continue to increase among people 65 and older. The proportion of Americans with at least a bachelor's degree grew from 3.4 percent in 1950 to 17.4 percent in 2003.

In addition to a prediction that by 2030 more than one-quarter of the older population is expected to have undergraduate degrees, the report found that the number completing high school quadrupled from 1950 to 2003, from 17 percent to 71.5 percent.

In 2003, older Americans were 83

Extendicare Considers Sale, Company Shake Up

Dissatisfied with current share prices, Canadian-based Extendicare announced its exploration of either a sale or restructuring that may impact its long term care division, according to the company's chief executive officer.

Its wholly owned U.S. subsidiary Extendicare Health Services (EHSI) operates 439 skilled nursing and assisted living facilities through the brand name Assisted Living Concepts.

"We believe our current share price has not been reflective of the company's under-

lying operational performance and financial results," said Mel Rhinelander, president and chief executive officer of Extendicare. "As a result the board of directors is undertaking a review of strategic initiatives that might add value for our shareholders."

Extendicare announced the appointment of an independent committee of directors and has hired Lehman Brothers to advise the company on the potential sale or restructuring.

For 2005, EHSI's revenue from continuing

operations increased 29.6 percent over 2004, to \$271.5 million. However, the division's 2005 net income on continuing operations was \$57.8 million, compared with \$76.5 million in 2004. The company said that 2004 results included a \$21.8 million one-time after-tax gain.

Extendicare purchased Assisted Living Concepts (ALC) on Jan. 31, 2005. After almost an entire year of operations, ALC has contributed \$169.1 million to the company's 2005 revenue.

—Lisa Gelhaus

percent Caucasian, 8 percent African American, 6 percent Hispanic, and 3 percent Asian. By 2030, the report estimates that 72 percent of older Americans will be Caucasian, 11 percent Hispanic, 10 percent African American, and 5 percent Asian.

Similar to other reports about the population explosion among baby boomers, this study found that the population aged 65 and over will double in size within the next 25 years. By 2030, almost one in five Americans (72 million) will be 65 years or older, and individuals aged 85 and older now

comprise the fastest growing segment of the U.S. population.

Familial relationships also have changed dramatically. In 1960, only 1.6 percent of older men and 1.5 percent of women aged 65 and older were divorced. By 2003, 7 percent of older men and 8.6 percent of older women were divorced and had not remarried, and among people in their early 60s, 12.2 percent of men and 15.9 percent of women were divorced.

The survey also looked at the geographic distribution of older adults. In 2000, nine states had more than 1 mil-

lion people 65 and older: California, Florida, New York, Texas, Pennsylvania, Ohio, Illinois, Michigan, and New Jersey. The states with the highest percentage of people aged 65 and older are Florida, Pennsylvania, and West Virginia.

Data for the report were pulled from the 2000 U.S. Census, previous censuses, nationally representative surveys, recent population projections, and data compiled by other federal agencies such as the U.S. Department of Housing and Urban Development.

—Meg LaPorte

AHCA Outlines 2006 Agenda At Capitol Hill Briefing

At a recent Capitol Hill briefing, American Health Care Association (AHCA) President and Chief Executive Officer (CEO) Bruce Yarwood made clear that the association's No. 1 legislative agenda for the remainder of 2006 will be to prevent the Bush administration's proposed fiscal year 2007 cuts to Medicare and Medicaid from being enacted.

"The growing care needs of America's most vulnerable frail, elderly, and disabled are being jeopardized by the administration's proposed cuts, and our principle objective for 2006 is to prevent these funding reductions and work with Congress and the president to sustain ongoing care quality improvement in our nation's nursing homes," Yarwood told the standing-room-only gathering of reporters and key Capitol Hill staffers.

Other top AHCA priorities for 2006, Yarwood said, are confronting the difficulties the profession faces in maintaining a stable workforce, the potential impact of changes to policies involving asset transfers and quality fees (provider taxes), and the profession's continuing commitment to improving its use of information technology.



Left to right: Fran Kirley, Bruce Yarwood, and Toni Fatone address assembly.

Yarwood was joined by Toni Fatone, executive director of the Connecticut Association of Health Care Facilities, and Fran Kirley, president and CEO of Nexion Health, which operates 40 facilities in Texas, Louisiana, and Colorado.

Fatone stressed the importance of sustaining state Medicaid systems by any means necessary. "If the Bush administration's proposals to cut quality fees were to be implemented, it would represent a severe reduction in Medicaid funds—with long term care

patients taking the biggest hit," she said.

Kirley noted that cuts in Medicare and Medicaid would exacerbate an already critical workforce problem. "We already operate at a tremendous competitive disadvantage in the labor marketplace," he said. "This is the worst federal budget possible, put forward at the worst possible time. We will do everything in our power to let the public know why it is flawed and must be fixed."

—David Zuckerman

MDs Register Part D Concerns

Time-Consuming Hurdles Put Patients At Risk, Physicians Say

In response to reports of onerous restrictions imposed by the Medicare Part D prescription drug plans (PDPs) and their potential impact on patient health and safety, leadership of the American Medical Directors Association (AMDA) recently called on the Centers for Medicare & Medicaid Services (CMS) to extend the transition period and enrollment deadlines and require one-stop access to contact information, plan formularies, exceptions and appeals procedures, and forms for prior authorizations. AMDA Vice President Charles

Crececius, MD, addressed these and other concerns at the organization's recent meeting in Dallas, where he told an audience of nursing facility medical directors, attending physicians, and other long term care professionals that physicians were reporting long telephone waiting times; exceptions processes that require unreasonable documentation, such as clinical notes, lab results, and mini mental state examination scores; time-consuming forms; and prior authorizations for inexpensive drugs.

"Most PDPs have reported hours of

9 a.m. to 5 p.m., Monday through Friday," says Crececius. "Exceptions and appeals processes take longer than many of my patients have life expectancy. These procedures must be handled as expeditiously as a patient's condition requires or within specified time frames.

"PDPs don't seem to understand long term care and don't seem to know what the Beer's list is," he said, referring to the list of drugs and diagnoses/drug combinations recognized by CMS at F-tag 329, which could place a person over the age of 65 at greater risk of adverse drug outcomes.

AMDA's meeting included a general session at which Jeffrey Kelman, MD, chief medical officer for consumer and beneficiary choices at CMS, responded to AMDA's concerns.

Kelman, a certified medical director, acknowledged that formularies have the capacity to change their list of covered drugs. "But any negative changes to formularies must first be approved by CMS," he said. "I don't see [approvals of negative formulary changes] as a possibility."

In response to a physician's question about CMS' purportedly vague guidance surrounding the "steering" of beneficiaries to certain PDPs, Kelman said that "when a physician makes a decision in the patient's best interest [regarding which PDP is best for that patient], no one will think that's a conflict of interest."

Meanwhile, Department of Health and Human Services Secretary Michael Leavitt said recently that he is beginning to look at the next plan year for Part D. "I can tell you that Medicare Part 2 will be much informed by what we've learned from [the first year]. The market has very clearly driven the prices down, and we believe the mar- ➤

Transfer From ALF To SNF Examined

A study published in the February 2006 issue of the *Journal of the American Medical Directors Association* found that dementia and neuropsychotic symptoms did not increase an assisted living resident's risk of transition to a skilled nursing facility (SNF). "Since one of the missions of assisted living is to provide a stable environment for long term care, it is important to know what factors put patients at risk for transition from an assisted living facility [ALF] to a SNF," the study's author said.

The study hypothesized that the risk factors for transition to a SNF would be similar to those found in independent living settings, which included declining health, dementia, dementia-related problem behaviors, need for supervision with activities of daily living, and lack of living spouse.

But surprisingly, the study found that the risk factors for transition from an ALF to a SNF were more likely to be blamed on declining health, chronic pain, appetite changes, and being widowed—not dementia and neuropsychiatric symptoms.

Among the 198 participants, 29 transitioned to SNF care, and while they had a

shorter survival time from assessment to endpoint, their total length of stay in assisted living, from admission to study endpoint, was similar to those who remained in assisted living. With means of 3.4 and 3.2 years, respectively, the rates are comparable to other published national estimates of 3.5 years.

According to the study's authors, the findings "reinforce the impression that assisted living facilities are effectively functioning as dementia care units." The researchers further concluded that the study illuminates the need for training and education on dementia care in assisted living and noted the comparison of survival rates (37 months) to a Canadian study that found a survival rate of 41 months for community-dwelling individuals with dementia.

Since the factors governing survival time in assisted living are similar to those for community-dwelling elderly, the researchers suggested that they are important in improving care and accurately predicting care needs for the growing assisted living population of the future.

—Meg LaPorte

ket will also simplify this program,” he said. “It’s clear that one of the things that we have learned is the need for simplification and standardization. I’m looking forward to the day, for example, when we can have a single form that can be applied to all of the plans. These are things that I believe will be enhancements.”

Using what CMS described to the American Health Care Association as its “strongest language to date,” the agency sent a letter to the PDPs in late March reminding them that there are a number of important steps to ensure a meaningful transition. These steps include “making arrangements to continue to provide necessary drugs to an

enrollee via an extension of the transition period, on a case-by-case basis, to the extent that his or her exception request or appeal has not been processed by the end of the minimum transition period.”

Finally, CMS told the PDPs, “we would expect that in situations where plans are unable to meet established time frames for decision making or forwarding cases or files to MAXIMUS [CMS’ Part D appeal contractor], affected enrollees should be given a temporary supply of the requested prescription drug (where not medically contraindicated) until the case is fully resolved or MAXIMUS issues a reconsideration decision.”

In other news, CMS has shifted the effective date of Part D coverage for Medicare beneficiaries who sign up for the program and subsequently apply for Medicaid.

Under the revised guidance to PDPs, these dual eligibles will be covered retroactively to the start of their Medicaid eligibility, or Jan. 1, 2006, whichever is later.

CMS continues to advise patients entering a long term care facility on Medicaid spend-down to enroll in Medicare Part D and choose a “below the benchmark” plan, apply for Medicaid, and apply for a low-income subsidy.

—Meg LaPorte

RUGs Review Shows Coding Variations

A recent review of resource utilization group (RUG) claims conducted by the Department of Health and Human Services Office of Inspector General (OIG) revealed that 26 percent of a random sample of RUG claims submitted by skilled nursing facilities (SNFs) were different from those generated based on the agency’s review of evidence in the medical record. Compared to a 2001 OIG review that found 76 percent of a random sample of RUG claims were inconsistent with the medical record, the current study results represent a significant improvement in the assignment of RUG categories at the facility level.

The recent report was produced as a followup to OIG’s 2001 recommendation that another review be conducted to further determine the extent to which RUGs on claims submitted by SNFs are different from those generated based on evidence in the medical record.

According to OIG, 22 percent of claims in the sample had a RUG with a higher associated payment rate than the one generated based on evidence in

the medical record, which OIG noted could represent potential overpayments. The remaining 4 percent in the sample had a RUG with a lower associated payment rate.

The study was conducted through an independent review of the minimum data set (MDS) and other documentation in the medical record on a random sample of 272 claims submitted by SNFs and from interviews with staff responsible for completing the MDS at the facilities. The reviewers determined whether the responses submitted by SNFs on the 108 MDS items used to generate the RUGs were consistent with documentation in the rest of the medical record. If a particular response to an MDS item was not consistent, the reviewer recoded that item and used it to calculate a new RUG.

While OIG emphasized that the study does not determine the extent to which claims submitted by SNFs are medically necessary or adequately supported by medical documentation, it did calculate potential effects of these differences on total Medicare payments. According to its calculations,

which took the net difference between the payment amounts for the RUGs on the claims submitted by SNFs and the payment amounts for RUGs generated based on review of the medical record, there were \$542 million in potential Medicare overpayments for fiscal year 2002.

Among the inconsistent claims found by OIG reviewers, 11 MDS items were most frequently inconsistent with documentation in the rest of the medical record. These items had one or more of the following characteristics: a look-back period (observation over time), multiple assessors (two or more staff assessed a patient to determine these items), or calculations.

In an effort to comply with OIG recommendations, CMS has taken steps to ensure that SNFs complete the MDS accurately and assign each patient to the correct RUG. To that end, CMS plans to continue the Data Assessment and Verification (DAVE) project and more carefully examine the 11 MDS items that were found to be most often inconsistent with the rest of the medical record.

—Meg LaPorte

By The Numbers



Scores represent the percentage of family members who gave "Excellent" and "Good" ratings on the survey item "Recommendation of this facility to others" based on "Length of stay." Source: Nursing Home Family Satisfaction Survey data collected in 2005 by My InnerView Inc.™ (www.myinnerview.com)